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CHAPTER TWENTY-THREE

HOSPITAL REIMBURSEMENT PROGRAM

Chapter 23. Hospital Reimbursement Program.

Rule No. 560-X-23-.01 Introduction

(1) This Chapter of the Alabama Medicaid Administrative Code has been promulgated by the Alabama Medicaid Agency (Medicaid) as a guide for providers of Medicaid hospital care. This Chapter is applicable to all hospitals participating in the Alabama Medicaid Program.

(2) The Alabama Medicaid Program is administered by Medicaid under the direction of the Governor's Office. Reimbursement principles for hospitals, including generally accepted accounting principles, principles included in the State Plan, and those mandated by federal Medicaid regulations, are outlined in the following sections of this Chapter. These principles, hereinafter referred to as "Medicaid Reimbursement Principles," are promulgated by Medicaid to provide reimbursement of hospital costs which must be incurred by efficiently and economically operated hospitals. These principles are not intended to be all inclusive and additions, deletions, and changes to them will be made by Medicaid on a periodic basis, as required. Hospitals are urged to familiarize themselves fully with the following information as cost reports must be submitted to Medicaid in compliance with this Chapter.

(3) If this Chapter is silent on a given point, Medicaid may impose a reasonableness test on a reported cost. Reasonableness may be determined through inquiries including, but not limited to, the following:

(a) Does the cost as reported comply with generally accepted accounting principles?

(b) Is the cost reasonable on its own merit?

(c) How does the cost compare with that submitted by other hospitals furnishing comparable levels of care?

(d) Is the cost related to patient care and necessary to the operations of a hospital which is efficiently and economically operated?

(e) Does the cost represent a bona fide attempt by hospital management not only to refuse to pay more than the prevailing market price for goods and services, but to also economize by minimizing the purchase price of goods and services?

(f) Do the policies, procedures, and actions of management promote economic and efficient operation of the hospital?

(g) Is the total cost consistent with the policies of a "prudent buyer"?

(h) How is the cost treated by other third party payors?

(4) The principles presented herein are based on the "prudent buyer" concept. A hospital is expected to conduct business in an efficient and conservative manner, and to submit requests for reimbursement only for costs which are absolutely necessary to the conduct of an economically and efficiently operated hospital.

(5) Medicaid recognizes that there are many variables involved in operating a hospital; examples include the size of the facility, the levels of care offered, the intensity of care required, the geographical location, the available labor market, and the availability of qualified consultants. While considerable effort has been made to recognize such variables during the development of this Chapter, reported costs reflecting such variables which exceed the "prudent buyer" concept (as defined herein) or other applied tests of reasonableness will not be allowed by Medicaid. Medicaid will consider granting

variances from the Medicaid Reimbursement Principles whenever a hospital submits prima facie evidence
that it can provide a service in a more cost effective manner if such variance is permitted. Requests for such variances must be fully substantiated, include the reason why the alternative method is considered more appropriate, provide the total computed cost, and supply the effective date and any other supporting data as deemed necessary. Such rate request variance must be requested within 60 days of the date of the Agency rate notification letter.

(6) The hospital must keep records which document and justify costs. Only those costs which can be fully and properly substantiated will be allowed by Medicaid. Increases over amounts reported on ahospital's previous cost reports, except those increases inherent in normal inflation, will be closely examined for reasonableness.

(7) Nonallowable costs which are identified during either desk audits or on-site audits will be disallowed despite the fact that similar costs may have been allowed in previously filed cost reports.

(8) Medicaid is funded out of public funds, exacted from the taxpayers through state and federal taxes. Improper expenditures of these funds are an abuse of the fiduciary responsibility of the hospital to the taxpayer and will be treated as a misuse of public funds.

(9) To assure only necessary expenditures of public money, it will be the policy of Medicaid to:

(a) Conduct desk audits and on-site audits of facilities at the discretion of Medicaid.

(b) Determine audit exceptions in accordance with Medicaid Reimbursement Principles.

(c) Allow only prudent, reasonable, and necessary allowable costs and require prompt settlement of any amounts determined to be payable to or from Medicaid.

(10) In the event that desk audits or on-site audits by Medicaid reveal that a hospital persists in including nonallowable costs in its cost reports, Medicaid may refer its findings to the Medicaid Investigation Section, Medicaid Counsel, and/or the Alabama Attorney General for appropriate action.

(11) While the responsibility for establishing policies throughout the Medicaid Program rests with Medicaid, comments on the contents of this Chapter are invited and will be given full consideration.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq Rule effective June 9, 1986. Effective date of this amendment February 9, 1988.

Rule No. 560-X-23-.02 Definitions and Basic Concepts

(1) Accrual Method of Accounting - For Medicaid cost reporting purposes, allocating revenues to the accounting period in which they are earned and expenses to the period in which they are incurred. This must be done regardless of when cash is received or disbursed.

(2) Allowable Costs - The costs of services incurred by an efficiently and economically operated hospital which are not otherwise disallowed by the reimbursement principles established under this Chapter.

(3) Bad Debts, Charity, and Courtesy Allowances

(a) Bad debts are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims which are collectible in money within a relatively short time following services rendered.

(b) Charity allowances are reductions in charges made by the hospital because of the medical indigence of the patient. Costs of free care (uncompensated services) furnished under a Hill-Burton hospital obligation are considered charity allowances.

(c) Courtesy allowances are reductions from the normal charges for services received from the hospital. They may be offered to physicians, clergy, members of religious orders, and others as approved by the hospital. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

(4) Chapter - This Chapter (Chapter Twenty-Three) of the Alabama Medicaid Agency Administrative Code.

(5) Compensation of Owners - Compensation of individuals who have an ownership or a control interest in the hospital for services they perform in a necessary function.

(6) Control Interest - The existence of the ability of a person, partnership, or corporation, through direct or indirect ownership or other means, to influence or control the policies and/or actions of a hospital and/or other related entities.

(7) Cost Recovery Item - Income generated by an element of allowable cost. Examples of such income include the sale of medical records transcripts and cafeteria guest meal revenues.

(8) Cost to Related Organizations - The concept that transactions between a hospital and related parties are allowable costs at the lesser of fair market value or the actual cost incurred by the related party.

(9) Costs Related to Patient Care - The concept that allowable costs include only those costs related directly or indirectly to the provision of necessary patient care to Medicaid recipients.

(10) Depreciation - An appropriate allowance for the gradual charge-off of all capital assets used to render services covered by the Medicaid program.

(11) Educational Activities - Approved educational programs which include formally organized programs of study which have been certified by an appropriate federal, state, or other regulatory body.

(12) Facility - A structure licensed by the State of Alabama that has a valid Medicaid contract to provide covered inpatient hospital care to Medicaid recipients.

(13) Fair Market Value - The bona fide price in terms of cash at which an asset or service would be purchased by a willing buyer from a willing seller

dealing in an arms-length transaction, neither being under any compulsion to buy or sell, and both having reasonable knowledge of the relevant facts.

(14) Grants, Gifts, Private Donations or the Income From Such Items, and Income from Endowments

(a) Unrestricted grants, gifts, private donations or the income from such items, and income from endowments are funds, cash, real property, personal property or other property given to a hospital without restriction by the donor as to their use.

(b) Designated or restricted grants, gifts, private donations or the income from such items, and income from endowments are funds, cash, real property, personal property, or other property which must be used only for the specific purpose designated by the donor. This does not include unrestricted grants, gifts, private donations or the income from such items, or income from endowments which have been restricted for a specific purpose by the hospital.

(15) HCFA - The Health Care Financing Administration, an agency of the U. S. Department of Health and Human Services, its predecessors and its successors.

(16) Hospital Group - The grouping of hospitals for Medicaid reimbursement calculation purposes. There shall be four groups. These are:

(a) Urban: Hospitals located within a Metropolitan Statistical Area (MSA) or the successor of such MSA as defined by the U. S. Bureau of the Census.

Grouped According to Bed Size

0 to 100 licensed beds
101 to 250 licensed beds
251 to 500 licensed beds
501 + licensed beds

(b) Rural: Hospitals not located within an MSA or successor to an MSA.

(c) Hospitals Providing Unique or Specialized Services atypical to any class: Such classification shall be at the discretion of Medicaid. The criteria used by the Division of Licensure and Certification of the Alabama Health Department in licensing a hospital shall be considered by the Alabama Medicaid Agency in determining which hospitals should be classified as unique or specialized.

(d) Psychiatric Hospitals: Psychiatric Hospitals which are enrolled with Medicaid to provide inpatient psychiatric services to children under 21 years old and to adults who are over 65 years of age.

(17) Interest - Cost incurred for the use of borrowed funds.

(a) Necessary Interest - Incurred to satisfy a financial need of the hospital on a loan made for a purpose directly or indirectly related to patient care. Necessary interest cannot include interest on loans resulting in excess funds or investments.

(b) Proper Interest - Must be necessary as described above, incurred at a rate not in excess of what a prudent borrower would have to pay in the money market at the time the loan was made, and incurred in connection with a loan directly or indirectly related to patient care.

(18) Interim Per Diem Rate - A rate intended to approximate the hospital's actual allowable costs of services furnished, based on budgeted

information, until such time as actual allowable costs are determined and a prospective per diem rate is determined.

(19) Medicaid - The Alabama Medicaid Agency, its predecessors and its successors.

(20) Medicaid Inpatient Day - {for purposes of calculation of disproportionate share hospital payments in Rule 560-X-23-.16(10)} - The total number of Medicaid inpatient hospital days, including Medicaid nursery days, Medicaid HMO days, Medicaid maternity waiver days, and other States' Medicaid days, as documented in the most recent as-filed Alabama Medicaid uniform cost report for hospitals for the reporting period ending in the calendar year next preceding the current state fiscal year.

(21) Medicaid Inpatient Utilization Percentage - The total number of Medicaid inpatient days (including nursery days) in a cost reporting period, divided by the total number of the hospital's inpatient days (including nursery days) in that same period. Days for services provided under the Maternity Waiver Program, other States' Medicaid days or a Medicaid HMO shall be separately accumulated from days associated with services provided under the Medicaid Program. These days should be included in the overall Medicaid occupancy percentage for purposes of the disproportionate calculation for those hospitals meeting the criteria contained within Rule No. 560-X-23-.16(10) of this Chapter.

(22) Medicaid Prospective Per Diem Rate - The amount paid by Medicaid for hospital services provided to Medicaid patients for a one-day period based on actual cost information subject to various cost limits.

(23) Medicaid Reimbursement Principles - A set of rules, regulations, laws, and interpretations embodied in this Chapter which provide direction as to the allowability of costs incurred by hospitals for the inclusion of these costs in their prospective Medicaid inpatient reimbursement rates. These rules, regulations, laws, and interpretations are promulgated by the Alabama Medicaid Agency and are, in part, based on generally accepted accounting principles, principles included in the State Plan, and regulations required of the Alabama Medicaid Program by various federal and state laws and regulations.

(24) Patient Day - Any day that a bed is either occupied or reserved for a patient on an authorized and temporary leave of absence from the hospital. A day begins at 12:01 A.M. and ends 24 hours later. The midnight to midnight method must be used for Medicaid reporting purposes even if the hospital uses a different definition of patient days for statistical or financial purposes.

(25) Proprietary Hospital - A hospital, whether a sole proprietorship, partnership, or corporation, organized and operated with the expectation of earning profit for distribution to owners as distinguished from hospitals organized and operated on a not-for-profit basis.

(26) Prudent Buyer Concept - The principle of purchasing necessary supplies and services at a cost which is as low as possible without sacrificing quality.

(27) Purchase Discounts, Allowances, and Refunds of Expenses

(a) Discounts, in general, are reductions granted for the settlement of debts promptly or purchase of large quantities.

(b) Allowances are deductions granted for damage, delay, shortage, imperfection, or other causes, excluding discounts and returns.

(c) Refunds are amounts paid back or credits arising from overpayment.

(28) Reasonable Compensation - The compensation of an officer and/or an employee performing a necessary function in a hospital for remuneration which would ordinarily be paid for comparable services by a comparable hospital operating under comparable economic conditions.

(29) Reasonable Costs - Necessary and ordinary cost related to patient care which a prudent and cost-conscious hospital would pay for a given item or service.

(30) Related Party - A person, corporation, partnership, organization, or other entity that is associated or affiliated with and has control over, or is controlled by the hospital furnishing services or supplies to Medicaid recipients.

(31) Reporting Year - The twelve-month period upon which providers are required to file a uniform cost report for each fiscal year. The provider may elect the last day of any month as their fiscal year end for Medicaid cost reporting purposes.

(32) Research Costs - Those costs over and above the usual patient care which generally involve experimentation of a non-covered nature.

(33) Return on Equity Capital of Proprietary Hospitals - An allowance to proprietary hospitals which is based upon a reasonable return on the invested equity capital related to the provision of necessary patient care. Such allowance shall be eliminated over a three year period. Beginning with the 7/1/88 rate period, payment will be 75% of the amount as normally calculated (under Rule No. 560-X-23-.12); 7/1/89, 50%; 7/1/90, 25%, and zero thereafter.

(34) State Plan - The State Plan promulgated by the State of Alabama under Title XIX of the Social Security Act, Medical Assistance Program.

(35) Straight-Line Method of Depreciation - Depreciation charges spread equally over the estimated useful life of the asset. Useful lives shall be in accordance with applicable American Hospital Association guidelines.

(36) Teaching Hospital - A hospital which is affiliated with and under the control of a University in the State of Alabama which has an accredited school of medicine, medical research programs, and a broad range of residency programs, eg., surgery, internal medicine, pediatrics and obstetrics.

(37) Training Hospital - A hospital with one or more accredited residency programs which are not controlled by a University in the State of Alabama.

(38) Trend Factors - A statistical measure of the change in costs of goods and services purchased by a hospital during the course of one year. The trend factors to be used for purposes of the Chapter shall be computed based upon the Health Care Costs - National Forecasts - HCFA Type - Hospital Market Basket Index of Total Operating Costs (excluding capital costs), as published by Data Resources, Inc. (DRI). Wage and salary proxies of this index shall be used for purposes of trending any applicable medical education costs.

(39) Low Income Utilization Rate - the sum of the following two fractions expressed as a percentage:

(a) Total net Medicaid inpatient revenues paid (including accruals) to the hospital, plus the amount of any cash subsidies received directly from State and local governments in the cost reporting period. Divided by the total amount of net inpatient revenues paid (including accruals) to the hospital including the amount of any cash subsidies received directly from State and local governments in the same cost reporting period; and

(b) The total amount of the hospital's gross charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment) in the cost reporting period, less the portion of any cash subsidies described in (36)(a) above, in the period, reasonably attributable to inpatient services. Divided by the total gross amount of the hospital's charges for inpatient services in the hospital in the same cost reporting period. The total inpatient charges attributed to charity care shall not include any contractual adjustments.

Authority: State Plan, Attachment 4.19-A, pages 3-5A, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986. Amended October 11, 1986; September 9, 1987; May 25, 1988 and November 10, 1988, April 14, 1989. Emergency rule effective October 1, 1991. Amended January 14, 1992; September 11, 1992 and May 13, 1993. Effective date of this amendment is January 11, 1996.

Rule No. 560-X-23-.03 Capital Related Costs

(1) Depreciation

(a) Straight-Line Method - The straight-line method of computing depreciation shall be required for all depreciable assets. Under the straight-line method, the annual allowance shall be determined by dividing the cost of the asset by the years of useful life. This method produces a uniform allowance each year.

If an accelerated method has been previously approved for assets in use on the date of the adoption of these regulations, such methods may be continued for those assets.

1. Depreciation for Year of Purchase or Disposal - Where an asset is purchased or disposed of during the year, only a fractional amount of the annual depreciation may be treated as a reimbursable cost as follows:

(i) Buildings and fixed equipment - Based on number of months actually in use.

(ii) Major movable equipment and other equipment - Based on number of months actually in use or the half year convention. Either method elected must be applied on a consistent basis.

(b) Useful Life of Depreciable Assets - The estimated useful life of an asset shall be its time of expected usefulness to the hospital, not necessarily the inherent useful or physical life. In initially selecting a proper useful life for computing depreciation under the Medicaid program, hospitals must use the useful life guidelines published by the American Hospital Association (1973 Edition of the Chart of Accounts for Hospitals for assets acquired before January 1, 1982, the 1978 Edition of the Estimated Useful Lives of Depreciable Hospital Assets for assets acquired on or after January 1, 1982 but before January 1, 1983, the 1983 Edition of the Estimated Useful Lives of Depreciable Hospital Assets for assets acquired on or after January 1, 1983, and the 1988 Edition of the Estimated Useful Lives of Depreciable Hospital Assets for Assets Acquired on or after January 1, 1988.) The use of 1978, 1983, and the 1988 editions also allows more detailed component lives for building and

building equipment, e.g., automatic doors, canopies, computer flooring, etc. Each component may be depreciated separately on the basis of the useful life of each component rather than on the basis of the useful life of the entire building. A composite useful life may also be used for a class or group of assets. If a composite life is used for major movable equipment, the useful life shall not be less than ten (10) years.

Computer software shall be capitalized if purchased in conjunction with computer hardware and shall be depreciated over the life of the hardware. Subsequent purchases of computer software shall be capitalized and depreciated over a minimum of five (5) years. Internally generated computer software may be expensed.

Generally, building additions shall be depreciated over their economic useful lives except where the hospital can demonstrate that a shorter useful life is justified. All exceptions must be requested in writing and written approval must be given by Medicaid prior to inclusion in a cost report.

1. Useful Life - Leasehold Improvements - The cost of improvements which are the responsibility of the hospital under the terms of a lease shall be depreciated over the useful life of the improvement or the remaining term of the lease, whichever is shorter. The term of the lease includes any period for which the lease may be renewed, extended, or continued following the exercise of an option by the hospital. In the absence of an option, reasonable interpretation of past acts of the lessor and hospital pertaining to renewal will be utilized, unless the hospital can establish that it will probably not renew, extend, or continue the lease.

2. Change in Estimated Useful Life - A change in the estimated useful life may be made when clear and convincing evidence justifies a redetermination of the useful life used by the hospital. Such a change must be requested in writing and written approval must be given by Medicaid before inclusion in the cost report. The change is effective with the reporting period immediately following the period in which the hospital's submitted request is approved. When there is a change in the useful life of an asset, the undepreciated balance on the date of change is depreciated over the new remaining useful life under the straight-line method.

(c) Cost Basis

1. Historical Cost - Historical cost is the cost incurred by the present owner in acquiring an asset and preparing it for use. Generally such cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees, consulting fees, and related legal fees. However, the historical cost shall not exceed the lower of (1) current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase, or (2) fair market value at the time of the purchase, for assets acquired prior to July 18, 1984.

Acquisition costs (feasibility studies, accounting or legal fees, etc.) are not reimbursable costs for sales occurring on or after July 18, 1984, if such costs have been capitalized and amortized under the program as a part of the seller's cost prior to this date.

For facilities purchased, transferred, or otherwise lawfully conveyed subsequent to July 18, 1984, the cost basis for the depreciable assets is limited to the lower of the following: (1) the allowable original acquisition cost to the party desiring to sell, transfer, or otherwise lawfully convey, or (2) the total price paid for the facility by the purchaser as allocated to the individual assets.

2. Interest During Period of Construction - Net interest costs incurred during the period of construction for a capital project related debt must be capitalized as a part of the cost of the facility. The period of construction is considered to extend to the date the facility is put into use

for patient care and patients are actually admitted to or otherwise utilize the services of the capital project.

If the construction is an addition to an existing facility, interest incurred during the construction period on funds borrowed to construct the addition shall be capitalized as a cost of the addition. After the construction period, interest on the loan may be allowable as an operating cost.

Any financing costs amortized during the period of construction shall be capitalized as a part of the cost of the facility constructed.

3. Intergovernmental Transfer of Facilities - In the case of intergovernmental transfers, the basis for the depreciation of assets transferred under appropriate legal authority from one governmental entity to another is:

(i) The historical cost (as defined above) incurred by the present owner in acquiring the asset under a bona fide sale.

(ii) The fair market value at the time of donation under a bona fide donation of the asset. (An asset is considered "donated" when a governmental entity acquires the asset without assuming the functions for which the transferor used the asset or making any payment for it in the form of cash, property, or services.) If the donated asset was used or depreciated under the Medicaid program and then donated to a hospital, the basis of depreciation for the asset will be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the program. (The "net book value" of the asset is defined as the depreciable basis used under the program by the asset's last participating owner, less the depreciation recognized under the program.)

If neither subparagraph (i) nor (ii) applies (for example, if the transfer was solely to facilitate administration or to reallocate jurisdictional responsibility, or the transfer constituted a taking over in whole or in part of the function of one governmental entity by another governmental entity) the basis for depreciation shall be:

(iii) With respect to an asset on which the transferor has claimed depreciation under the Medicaid program, the transferor's basis under the program prior to the transfer.

(iv) With respect to an asset on which the transferor has not claimed depreciation under the Medicaid program, the cost incurred by the transferor in acquiring the asset (not to exceed the basis that would have been recognized had the transferor participated in the program), less depreciation calculated on the straight-line basis over the life of the asset to the time of transfer.

4. Historical Cost, Trade-Ins - When an asset is acquired by trading in an asset that was depreciated under the program, the cost of the new asset is the sum of (1) the undepreciated cost (or fair market value if no cost is assigned) of the asset traded in and (2) any cash or other assets transferred or to be transferred to acquire the new asset. This basis shall not exceed the lower of the list price or fair market value.

5. Cost Basis of Facility Transferred as an On-Going Operation - For facilities purchased, transferred, or otherwise lawfully conveyed prior to July 19, 1984, the cost basis for the depreciable assets is limited to the lowest of the following: (1) the total price paid for the facility by the purchaser as allocated to the individual assets; (2) the total fair market value of the facility at the time of the sale, as allocated to the individual assets; (3) the combined fair market value of the individually identified assets at the time of the sale; or (4) the current reproduction costs of the depreciable assets, depreciated on a straight-line basis over the life of the assets to the time of the sale.

For facilities purchased, transferred, or otherwise lawfully conveyed subsequent to July 18, 1984, the cost basis for the depreciable assets is limited to the lower of the following: (1) the allowable original acquisition cost to the party desiring to sell, transfer, or otherwise lawfully convey, or (2) the total price paid for the facility by the purchaser as allocated to the individual assets.

If the issue arises, the purchaser has the burden of proving that the transaction was a bona fide sale. If the burden of proof is not met, the cost basis may not exceed the seller's cost basis, less accumulated depreciation.

This rule does not apply to intergovernmental transfers, to which special rules apply.

6. Revaluation of Assets in Cases Involving Acquisition of Stock - A revaluation of asset cost occurs only when the stock transfer is between unrelated parties and brings about either a statutory merger under the corporation laws of Alabama or applicable corporation laws of other states or a consolidation resulting in the creation of a new corporate entity. There must be a change in ownership of a corporation's assets, as opposed to a mere purchase of stock in order for the revaluation to be allowed. If a revaluation of assets is allowed, the depreciable cost will be limited to that allowed by other rules of this section.

7. Guidelines for Capitalization of Historical Costs and Improvement Costs of Depreciable Assets

(i) Acquisitions - If at the time of its acquisition, a depreciable asset has an estimated useful life of at least two years and a historical cost of at least $500, its cost must be capitalized and written off ratably over the estimated useful life of the asset on a straight-line basis. If a depreciable asset has a historical cost of less than $500 or a useful life of less than two years, its costs is allowable in the year it is acquired. The hospital may, if it desires, establish a capitalization policy with lower minimum criteria, but under no circumstances may the above criteria be exceeded.

(ii) Betterments and Improvements - Betterments and improvements extend the life or increase the productivity of an asset; whereas repairs and maintenance either restore the asset to, or maintain it at, its normal or expected service life. Repair and maintenance costs are allowed in the current accounting period.

If the cost of a betterment or improvement to an asset is $500 or more and the estimated useful life of the asset is extended beyond its original estimated useful life by at least 2 years, or if the productivity of the asset is increased significantly over its original productivity, then this cost must be capitalized and written off ratably over the remaining estimated useful life of the asset as modified by the betterment or improvement. As in the previous section, lower minimum criteria may be used if desired.

(iii) Sale and Leaseback and Lease-Purchase Agreements

(I) Sale and Leaseback Agreements - Rental Charges - Where a hospital enters into a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment, the incurred rental specified in the agreement is includable in allowable costs if the following conditions are met:

I. The rental charges are reasonable based on consideration of rental charges of comparable facilities and market conditions in the area, the type, expected life, condition and value of the facilities or equipment rented, and other provisions of the rental agreements.

II. Adequate alternate facilities or equipment which would serve the purpose are not or were not available at lower cost.

III. The leasing is based on economic and technical considerations.

Unless all of the above conditions are met, the rental charge cannot exceed the amount (such as interest on a mortgage, taxes, depreciation, insurance and maintenance costs) which the hospital could have included in reimbursable costs had it retained legal title to the facilities or equipment.

(II) Lease Purchase Agreements - Rental Charges

I. Definition of Virtual Purchase - Some lease agreements are essentially the same as installment purchases of facilities or equipment. The existence of any of the following conditions will generally establish that a lease is a virtual purchase:

A. The lease transfers ownership of the property to the lessee by the end of the lease term.

B. The lease contains a bargain purchase option.

C. The lease term is equal to 75 percent or more of the estimated economic life of the leased property.

D. The present value at the beginning of the lease term of the minimum lease payments equals or exceeds 90 percent of the fair value of the leased property less any related investment tax credit retained by the lessor.

II. Treatment of Rental Charges - If the lease is a virtual purchase and is not capitalized by the hospital, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount such as straight-line depreciation, insurance, and interest which the hospital could have included in allowable costs if it had obtained legal title to the asset. The difference between the amount of rent paid and the amount of rent allowed as rental expense is considered a deferred charge and should be capitalized as part of the historical cost of the asset when the asset is purchased. If the asset is returned to the owner, instead of being purchased, the deferred charge may be expensed in the year the asset is returned. Where the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be expensed to an amount not exceeding the cost of ownership. On the other hand, if the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be expensed to the extent that the amount paid approaches fair rental value.

(iv) Fair Market Value - Donated Assets - Fair market value is the price that the asset would bring by arms length negotiation between a well-informed buyer and a well-informed seller at the date of acquisition. Usually the fair market price will be the price at which bona fide sales have been consummated for assets of like type, quality and quantity in a particular market at the time of acquisition. An asset is considered donated when the hospital acquires the asset without making any substantial payment for it in the form of cash, property, or services. When the hospital makes any such payment in acquiring the asset, this payment, and not the fair market value, is considered to be the historical cost of the asset.

In the case of donated assets, depreciation should be based on the fair market value of the assets at the time of donation. However, there is one exception to this general rule applicable to assets that have been used or depreciated under the Medicaid program and then donated to a hospital. In this case, the basis of depreciation for the assets will be the lesser of (1) the fair market value of the asset, or (2) the net book value of the asset in the hands of the owner last participating in the Medicaid program.

It is the responsibility of the hospital to satisfy Medicaid as to the allowable basis for donated assets.

(v) Regulatory Approval - Medicaid reserves the right not to reimburse depreciation and interest expense related to asset purchases and/or leases not previously approved by Medicaid. With respect to asset purchases and/or leases related to new services on or after July 1, 1986, the hospital must request, in advance of a Medicaid contract application, a determination from Medicaid as to whether the depreciation, interest, and other capital-related costs may be included in allowable Medicaid cost. This rule does not apply to replacement of equipment.

8. Disposal of Assets - Depreciable assets may be disposed of through sale, scrapping, trade-in, donation, exchange, demolition, abandonment, permanent removal from service, or involuntary conversions such as condemnation, fire, theft or other casualty. If disposal of a depreciable asset results in a gain or loss, adjustment shall be necessary in the hospital's allowable cost. The amount of gain included in the determination of allowable cost is limited to the amount of depreciation previously included in allowable costs. The amount of loss included is limited to the undepreciated basis of the asset. An asset which has been retired from active service, but is being held for standby or emergency services, may continue to be depreciated. An asset which has been retired from active service, but is not being held for standby or emergency services, may not continue to be depreciated, but may qualify for loss calculation in accordance with other provisions of this Chapter.

A gain or loss is computed by calculating the difference between the sales price, insurance reimbursement and/or other amounts received for the assets and its undepreciated book value for Medicaid reimbursement purposes. For assets acquired prior to the beginning of the Medicaid program (January 1, 1970) or the date of participation, Medicaid will only recognize that portion of gains and losses attributable to participation under the program. The Medicaid applicable percentage is computed by dividing depreciation allowed under the Program by total depreciation taken on the asset.

Annual net gains and losses included in allowable cost will be limited to 10% of the hospital's total allowable depreciation for the year, with an excess being carried forward to the subsequent year(s), subject to the same annual 10% limitation.

9. Gains and Losses Attributable to Changes in Ownership - Gains and losses attributable to sales of facilities in connection with a change of ownership of the hospital are subject to the following rules.

(i) Losses are not recognized.

(ii) Gains are recognized by requiring the seller to repay the Medicaid program its share of the gain within 30 days after demand is made by Medicaid. If the seller does not make arrangements to pay the amount due to the Agency within thirty days of demand, the obligation shall then become the obligation of the purchaser and shall be deducted from the monthly payments ordinarily due the purchaser from the Agency.

(iii) Medicaid's share will be computed by allocating a portion of the gain to each year in which depreciation was taken. For those years in which the asset was used and depreciation claimed for Medicaid reimbursement, a portion of the gain will be recaptured based upon the ratio of Medicaid allowable cost to total allowable costs.

(iv) The rules relating to recapture of gains on sale or disposal will remain in effect for two years after a hospital terminates participation in the Medicaid program.

(v) Consideration may be given in situations where the hospital's per diem rate was limited by ceilings imposed by other regulations. Cost components of this rate, which may be limited by a ceiling, will bear a

pro-rata share of limitation. Depreciation costs remaining and reimbursed after limitation will be subject to recapture.

(2) Interest

(a) General - Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for use of funds borrowed for a relatively short term, usually for normal day-to-day operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquiring facilities and equipment, and making capital improvements. Generally, loans for capital purposes are long-term loans.

Necessary and proper interest on both current and capital indebtedness is an allowable cost.

1. Necessary - Necessary requires that the interest:

(i) Be incurred on a loan made to satisfy a financial need of the hospital. Interest on loans which result in excess funds or investments are not considered necessary.

(ii) Be incurred on a loan made for a purpose reasonably related to patient care.

(iii) Be reduced by investment income except where such income is from restricted gifts and grants, which are held separate and are not commingled with other funds. Income from funded depreciation or the hospital's qualified pension or deferred compensation fund is not used to reduce interest expense, providing that special rules governing the use of such funds as outlined in this Chapter are followed.

2. Loans Not Reasonably Related to Patient Care - The following types of loans are not considered to be for a purpose reasonably related to patient care:

(i) That portion of the cost of loans made to finance the acquisition of an asset that exceeds the historical cost or the allowable cost basis for Medicaid depreciation purposes.

(ii) Loans made to finance capital stock acquisitions, mergers, or consolidations for which revaluation of assets is not allowed.

In determining whether a loan was made for the purpose of acquiring a facility, owner's funds will be applied first to the tangible assets and then to goodwill and other intangible assets.

3. Proper - Proper requires that interest:

(i) Be included at a rate not in excess of what a prudent borrower would have had to pay in the open money market existing at the time the loan was made.

(ii) Be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans from the hospital's donor-restricted funds, the funded depreciation account, or hospital's qualified pension or deferred compensation fund.

(b) Borrower - Lender Relationship

1. To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or any other relationship to the borrower.

2. Where funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the hospital's qualified pension or deferred compensation fund where such deposits are used for other than the purpose for which the fund was established.

(c) Interest Expense of Related Organizations - Where a hospital leases facilities from a related organization and the rental expense paid to the related organization is not allowable as a cost, the costs of ownership of the leased facilities are allowable costs of the hospital. For example, mortgage interest paid by the related organization is allowable as an interest cost to the hospital to the extent that it does not exceed amounts which would be allowable under all applicable Medicaid regulations.

(d) Net of Investment Income - All investment income, including interest, dividends, net gain from sales of securities, (but excluding investment income derived from recognized funded depreciation, qualified pension or deferred compensation funds, or donor restricted funds which are identifiable in the hospital's records) must offset interest expense.

In cases where a hospital has interest on working capital loans or unallowable interest, the investment income offset must be applied in the following order:

1. Working capital loan interest
2. Capital interest
3. Unallowable interest

Investment income in excess of interest expenses shall not offset other costs.

(e) Capitalized Leases Treated as Purchases - The lessee shall record a capital lease as if the transaction was actually a purchase. Accordingly, fixed and other assets are recorded at acquisition cost, i.e., the cash price with a corresponding liability representing the present value of the obligation. The current AICPA Statement of Financial Accounting Standards No. 13 (SFAS No. 13) shall provide the definitive determination of when and how leases shall be capitalized.

During the lease term, each lease payment will be allocated between a reduction of the obligation and interest expense so as to produce a constant periodic rate of interest on the remaining balance of the obligation.

In leases that contain a residual guarantee at the end of the lease term, amortization of the obligation shall reflect such residual.

(f) Funded Depreciation - Funding of depreciation is the practice of placing funds, including nonborrowed bond reserve and sinking funds, in a segregated account(s) for the acquisition of depreciable assets used in rendering patient care or for other capital purposes related to patient care. Other capital purposes include capital debt liquidation, such as principal payments for bonds and mortgages, nonborrowed bond reserve and sinking funds to the extent used for a capital purpose. Funds must be on deposit for at least six months in readily marketable investments prior to being claimed as funded depreciation. The investments must assure availability and conservation of funds. Income earned on investments which do not meet this condition shall be offset against allowable interest expense.

Allowable funded depreciation cannot exceed accumulated depreciation on capital assets related to patient care. Accumulated depreciation cannot exceed that computed by using useful lives and depreciation methods allowed by this Chapter. Investment income on excess funded depreciation shall reduce interest expense.

Although funding of depreciation is not required, it is strongly recommended as a means of conserving funds for the acquisition of depreciable assets as described above. The following provisions apply to funded depreciation.

1. Interest Paid on Loans from Funded Depreciation - When the general fund of the hospital borrows from funded depreciation to obtain necessary working capital for normal operating expenses to render patient care, interest incurred by the general fund is an allowable cost. However, the average interest rate paid on such loans cannot exceed the average investment

return rate on the depreciation fund. The "necessary and proper" requirements apply to such loans. When the general fund of the hospital borrows from funded depreciation to acquire depreciable assets to render patient care, interest paid by the general fund to the funded depreciation account is not an allowable cost. Hospitals are expected to use the funded depreciation for that purpose.

Funding of depreciation from general funds will not be recognized to the extent of any working capital loans the depreciation fund has outstanding and due from the general fund at the time of deposit. Deposits of general funds into the funded depreciation account must be first applied to reduce loans outstanding from the funded depreciation account to the general fund. Until such loans are repaid in full, general funds deposited in the funded depreciation account will be considered as repayments on the loans and, therefore, any subsequent interest expense of the general fund to the extent of the repaid loans is not allowable.

2. Interest or Other Income Earned by the Funded Depreciation Account - Where the hospital funds depreciation, the money in the fund should be invested to earn revenues. Investment income earned by the funded depreciation account attributable to cumulative allowable depreciation expense funded in periods either before, during, or after the hospital's participation in the Medicaid program is not a reduction of allowable interest expense, and is available for use at the hospital's discretion.

3. Money Borrowed to Fund Depreciation - Borrowed bond reserve and sinking funds are not allowable as funded depreciation, but the interest on such borrowing is allowable and income earned by the borrowed funds is applied as a reduction of interest expense.

(g) Cancellation or Restructuring of Debt Costs Subject to Special Rules Regarding Amortization

1. Recall of Debt Before Maturity - Without the Issuance of New Debt

Costs incident to the recall of debt before the date of maturity are considered debt cancellation costs and are allowable to the extent they are reasonable. Debt cancellation costs include recall penalties, unamortized discounts and expenses, legal and accounting fees, etc. These costs are reduced by any unamortized premiums. Allowable debt cancellation costs will not be reduced by any factor representing that portion of the debt life attributable to years before the hospital entered the Medicaid program.

In determining the reasonableness of the costs of recall debt before maturity, consideration must be given to the overall financial implications of the recall. The reasonableness of any costs incurred in connection with the recall of debt before maturity must take into account such approvals as may be required by authorized planning agencies.

(i) Treatment of Debt Cancellation Costs

When costs incident to debt cancellation plus the actual cost incurred on the debt during the hospital's reporting period are less than the amount of interest cost and amortization expense that would have been allowable in that period had the indebtedness not been cancelled, then the cost of debt cancellation, to the extent reasonable, is allowable in the year incurred.

However, when reasonable costs incident to debt cancellation plus the actual cost incurred on the debt during the hospital's reporting period exceed the amount of interest cost and amortization expense that would have been allowable in that period had the indebtedness not been cancelled, the maximum allowable cost in that period is the total amount of interest cost and amortization expense that would have been allowable in that period had the indebtedness not been cancelled. The excess is allowed as a cost in the subsequent period (again, to the extent that the amount does not exceed

the interest cost and amortization expense that would have been incurred in that subsequent period, and so on, until fully absorbed).

Debt cancellation costs are not interest payments and, therefore, should not be reduced by investment income in the period of cancellation or in subsequent periods.

2. Advance Refunding of Debt - Advance refunding is a refinancing technique which enables a hospital to replace existing debt prior to its scheduled maturity with new debt. Advance refunding is done for a variety of reasons including achieving a lower interest rate, improving cash flow, removing restrictive covenants, and increasing borrowing capacity.

(i) Definitions - For purposes of this section, the following definitions apply:

(I) Refunding Debt - New debt issued to provide funds to replace the refunded debt immediately or at a specified future date(s).

(II) Refunded Debt - Debt for which payment immediately or at a specified future date(s) has been provided by the issuance of refunding debt.

(III) Advance Refunding - A transaction in which refunding debt is issued to replace the refunded debt immediately or at a specified future date(s).

(IV) Defeasance Provision - A provision in the refunded debt instrument that provides the terms by which the debt may be legally satisfied and the related lien (if any) released without the debt necessarily being retired.

(V) Defeasance - Legal satisfaction of debt under the terms of a defeasance provision.

(ii) Allowable Costs - When a hospital defeases or repurchases debt incurred for necessary patient care through an advance refunding, the revenues and expenses associated with the advance refunding are treated as follows:

(I) Debt issue costs on the refunding debt must be amortized over the life of the refunding debt from the date the debt is incurred to scheduled maturity of the debt.

(II) Debt cancellation costs on the refunded debt are allowable as indicated below:

I. Redemption expenses and any other miscellaneous expenses (legal fees, initial trustee fees, feasibility studies, stamp fees, printing, etc.) are allowed as paid or accrued.

II. Annual authority and trustee fees are allowed as paid or accrued.

III. Call premiums or penalties are allowable in the period(s) the holders of the refunded debt receive the principal payment. Call premiums or penalties of serial bonds should be prorated over the scheduled maturity or recall dates on the basis of the proportionate principal repayments at each date.

(III) Unamortized discounts or premiums (reduction of debt cancellation costs) and debt issue costs of the refunded debt must continue to be amortized until the date the holders of the refunded debt will receive the principal payment (appropriately prorated in the case of serial bonds as in II. above).

(IV) Interest expense on the refunded debt is allowable on an annual basis as paid or accrued, whether by the hospital or by a trust. Similarly, interest expense on the refunding debt is allowable as paid or accrued. The amortized portion of discounts or premiums on the refunding debt is an adjustment to allowable interest expense. The interest income derived from the investment of the proceeds of the refunding debt must be used

to offset interest expense whether this interest income is earned by the hospital directly or through a trust.

The effect of the above treatment is to implicitly recognize any gain or loss incurred as the result of an advance refunding over the period from the date the refunding debt is issued to the date the holders of the refunded debt receive the principal payment, rather than immediately. The individual expense elements are the only costs which can be reimbursed in accordance with the above policy.

(iii) Limitation on Recognition of Costs - As with all costs incurred for funds borrowed, the costs associated with an advance refunding must meet the necessary and proper tests as well as the reasonable cost provisions. In addition, sinking funds available for liquidation of the refunded debt must be considered in a determination of necessary borrowing through advance refunding. On occasion, a hospital may borrow more than the amount required to advance refund the existing debt. If the additional borrowing is for the acquisition of depreciable assets, existing funded depreciation must be taken into account in determining the necessity of the excess borrowing.

Generally, the total net aggregate allowable costs incurred for all cost reporting periods related to the advance refunding cannot exceed the total net aggregate costs that would have been allowable had the advance refunding not occurred. However, in evaluating the necessity, propriety and prudence of an advance refunding, consideration may be given to factors such as cash flow needs or the necessity to remove a restrictive covenant that prevents the hospital from borrowing additional funds for an appropriate purpose. Excess aggregate costs incurred by the hospital due to advance refunding will be allowable only where the hospital can demonstrate to the satisfaction of Medicaid that compelling factors (such as those mentioned above) necessitated the advance refunding. Otherwise, the costs will be limited to the costs which would have been incurred if the old debt had not been refunded.

(iv) Treatment of Items for Equity Capital Purposes - All debts and debt proceeds associated with advance refunding incurred for necessary patient care are includable in the determination of equity capital. However, if interest expense is disallowed under the limitation expressed above, the debt (or unreasonable portion thereof) associated with the disallowed interest expense, as well as the related assets, must be excluded in the determination of equity capital.

(h) Financing, Origination, Issuance, and Discount Costs Amortizable Over the Life of the Debt

1. Prepaid Interest - Prepaid interest is the excess of the face value of a loan over the proceeds of the loan. It is the payment of interest in advance of the period over which the interest expense is incurred. These costs shall be amortized over the life of the related loan.

2. Finance Charges - Some lending institutions include in the costs of loans expenses related to the maintenance of records, collection of delinquent accounts, administration, etc., in addition to the charges for interest. These costs are known as finance charges, carrying charges, etc. These costs shall be amortized over the life of the related loan.

3. Mortgage Interest - A mortgage is a lien on assets given by a borrower to a lender as security for borrowed funds for which payment will be made over an extended period of time. Mortgage interest refers to the interest expense incurred by the borrower on a loan which is secured by a mortgage. Usually such loans are long-term loans for the acquisition of land, buildings, equipment, or other capital assets.

Mortgage loans are customarily liquidated by means of periodic payments, usually monthly, over the term of the mortgage. The periodic payments usually cover both interest and principal. That portion which is for

the payment of interest for the period is allowable as a cost of the reporting period to which it is applicable. In addition to interest expense, other expenses are incurred in connection with mortgage transactions. These may include attorney's fees, recording costs, transfer taxes and service charges which include finder's fees and placement fees. These costs, to the extent that they are reasonable, should be amortized over the life of the mortgage in the same manner as bond expenses. The portion applicable to the reporting year is an allowable cost.

4. Interest on Notes - A note is contractual evidence that funds have been borrowed. It is given to a lender by a borrower and states the terms for repayment. Interest on notes is allowable as a cost in accordance with the terms of the note to the extent that the interest relates to loan proceeds used either to acquire assets for use in the patient care activities or to provide funds for operations related to patient care.

If, under the terms of the loan, the interest is deducted when the loan is made (discounted), the interest deducted should be recorded as prepaid interest. A proportionate part of the prepaid interest is allowable as a cost in each period over which the loan extends.

5. Interest on Bonds - A bond is a debt instrument used by both corporations and governmental entities, usually for long-term capital requirements. A bond is evidence of a liability which assures bondholders of repayment. The terms of the bond are stated in the bond indenture and interest is usually stated as a fixed rate payable in periodic payments such as semi-annually. Interest on bonds is an allowable cost in accordance with the terms of the bond indenture, to the extent that the interest relates to bond proceeds used either to acquire assets for use in patient care activities or to fund operations related to patient care.

6. Bond Discount and Expenses - Where bonds are sold at a price below par or face value, the difference between par or face value and the selling price represents the amount of discount. Bond discount is, in effect, an adjustment of the interest rate, a premium which the issuing company allows to the purchaser to induce him to buy the bonds at the interest rate stated for the bonds. The discount is considered to be additional interest expense paid in advance and, therefore, is includable in allowable cost. The discount, together with any expense related to the issue, shall be amortized, using the straight-line method, over the period from the date of sale to the date of maturity of the bonds.

7. Bond Premium - Where bonds are sold at a price above face value, the difference between the face value and the selling price represents the amount of bond premium. It is paid by the buyer of the bonds to the selling organization and is actually an adjustment of the total interest expense which is realized when the bonds are sold. The amortized portion of the bond premium is a reduction of allowable costs.

The bond premium should be recorded as a deferred credit, and amortized proportionately over the life of the bonds. The portion applicable to each reporting period is a reduction of allowable interest costs for the reporting period. The bond premium should be recorded separately from bond expenses related to the issuance of bonds. Where the bond premium and the bond expenses are not separately recorded and identifiable, they are in effect netted and the entire amount allocable to the reporting period is considered as bond expenses.

(3) Other Capital-Related Costs

(a) General Rule - Other capital-related costs are limited to Other capital-related costs are limited to the following:

1. Taxes on land or depreciable assets used for patient care.

2. Leases and rentals, including licenses and royalty fees, for the use of depreciable assets.

3. The costs of minor equipment that are capitalized, rather than expensed.

4. Insurance expense on depreciable assets.

5. For proprietary hospitals, return on equity capital.

6. The capital-related costs of related organizations.

(b) Leases and Rentals

1. Subject to the qualification of other criteria of this section, leases and rentals, including licenses and royalty fees, of assets that would be depreciable if the hospital owned them outright, are includable in capital-related costs. The terms "leases" and "rentals of assets" signify that a hospital has possession, use, and enjoyment of the assets.

2. In some instances, a hospital may include incurred rental charges in its capital-related costs, as specified in a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment, only if:

(i) The rental charges are reasonable based on the consideration of rental charges of comparable facilities and market conditions in the area, the type, expected life, condition and value of the facilities or equipment rented, and other provisions of the rental agreements;

(ii) Adequate alternate facilities or equipment which would serve the purpose are not or were not available at lower cost; and

(iii) The leasing is based on economic and technical considerations.

3. If the conditions of sub-paragraph (b)(2) of this section are not met, the amount a hospital may include in its capital-related costs as rental or lease expense under a sale and leaseback agreement may not exceed the amount (including, for example, interest on a mortgage, taxes, depreciation and insurance costs) which the hospital could have included in capital-related costs had the hospital retained legal title to the facilities or equipment.

(c) Insurance

1. A hospital shall include in its capital-related costs the costs of insurance on depreciable assets used for patient care and insurance that provides for the payment of capital-related costs during business interruption.

2. If an insurance policy also provides protection other than that stated in (c) 1. above, only that portion of the premium related to the replacement of depreciable assets or the payment of capital-related costs in the case of business interruption is includable in capital-related costs.

(d) Property Taxes - Taxes assessed on the basis of some valuation of land or depreciable assets used for patient care should be included in capital-related costs. (Taxes not related to patient care, such as income taxes, are not allowable, and are therefore not included among either capital-related or operating costs.)

(e) Costs of Supplying Organizations

1. Supplying Organization Related to the Provider

(i) If the supplying organization is related to the hospital, a hospital's capitalrelated costs include the capital-related cost of the supplying organization.

(f) Costs Excluded From Capital-Related Costs - The following costs are not capital-related costs. To the extent that they are allowable, they must be included in determining each hospital's operating costs:

1. Costs incurred for the repair or maintenance of equipment or facilities.

2. Amounts included in rentals or lease payments for repair or maintenance agreements.

3. Interest expense incurred to borrow working capital (for operating expenses). Interest associated with working capital loans must be included in the Administrative & General cost center.

4. General liability insurance or any other form of insurance to provide protection other than for the replacement of depreciable assets or the payment of capital-related costs in the case of business interruption.

5. The costs of minor equipment that are charged off to expense rather than capitalized.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986. Amended November 10, 1986; August 10, 1987; May 25, 1988, July 12, 1988 and May 12, 1989. Emergency Rule effective June 20, 1989. Effective date of this amendment September 13, 1989.

Rule No. 560-X-23-.04 Bad Debts, Charity, and Courtesy Allowances

(1) Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost. Bad debts are uncollectible accounts arising from services rendered by a hospital. Charity and courtesy allowances constitute reductions in charges made by a hospital, respectively, to indigent patients, and to physicians, clergy, and others approved by the officers of the hospital.

(2) Allowances to Employees

Reductions in charges granted to employees as fringe benefits for medical services are not considered courtesy allowances. Employee allowances are usually given under employee hospitalization and personnel health programs.

The allowances themselves are not costs since the costs of the services rendered are already included in the hospital's costs. However, any costs of the services not recovered by the hospital from the charge assessed the employee are allowable as employee fringe benefits.

Allowances for services or goods to non-patients other than employees are non-allowable costs.

Authority: State Plan; Title XIX, Social Security Act, C.F.R.Section 401, et seq. Rule effective June 9, 1986.

Rule No. 560-X-23-.05 Cost of Educational Activities

(1) A hospital's allowable cost may include its net cost of approved educational activities. Net costs of approved educational activities are determined by deducting from the total costs of these activities, revenues a hospital receives from tuition. For this purpose, a hospital's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities.

(a) Approved Educational Activities - Formally planned pro- grams of study, which a hospital engages in to enhance patient care quality and which are licensed as required by State or Federal law, are "approved educational activities."

(b) Activities Not Within the Scope of Approved Educational Activities - The costs of the following activities are not approved educational

activities but may be recognized as normal operating costs and are reimbursed in accordance with applicable principles:

1. Orientation and on-the-job training;

2. Part-time education for bona fide employees at properly accredited academic or technical institutions (including other hospitals or related institutions) devoted to undergraduate or graduate work;

3. Costs, including associated travel expense, of sending employees to educational seminars and workshops which increase the quality of medical care or operating efficiency of the hospital;

4. Maintenance of a medical library;

5. Training of a patient or patient's family in the use of medical appliances;

6. Clinical training of students not enrolled in an approved education program operated by the hospital;

7. Cost for the planning and conduct of refresher and post-graduate programs related to the improvement of patient care; and

8. Other activities that do not involve the actual operation of an approved education program including the costs of interns and residents in anesthesiology who are employed to replace anesthetists.

(c) Approved Programs for Interns and Residents - to be allowable, an intern or resident program must be approved by the appropriate approving body.

(d) Other Approved Programs - In addition to approved medical, osteopathic, and dental intern ships and residency programs, recognized professional and paramedical educational and training programs now being conducted by hospitals, and their approving bodies, include the following:

Program	Approving Bodies
1. Cytotechnology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Patholo gists.
2. Dietetic internships	The American Dietetic Associ ation.
3. Hospital administra- tion residencies	Members of the Association of University Programs in Hospital Administration.
4. Inhalation therapy	Council on Medical Educa tion of the American Medical Association in collaboration with the Board of Schools of Inhalation Therapy.
5. Medical Records	Council on Medical Educa tion of the American Medical Association in collaboration with the Committee on Education and Registration of the

		American Association of Medical Record Librarians.
6.	Medical Technology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
7.	Nurse Anesthetists	The American Association of Nurse Anesthetists.
8.	Professional Nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
9.	Practical Nursing	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
10.	Pharmacy Residencies	American Society of Hospital Pharmacists.
11.	Physical Therapy	Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association.
12.	X-ray Technology	Council on Medical Education of the American Medical Association in collaboration with the American College of Radiology.

(e) Non-Hospital Operated Programs Supported by Hospitals - In cases where hospitals provide support to community approved nursing and paramedical education programs, use of hospital space and personnel for classroom and clinical training on the hospital's premises is an allowable cost as long as the hospital is receiving a benefit for its support such as an assurance of availability of trained staff.

Cost of services provided on other than the hospital premises is not an allowable cost.

(f) Revenues Received - Revenues received through tuition and scholarships shall be offset against educational expenses. Reimbursement from hospital personnel for meals, uniforms, books or supplies will be offset against

educational costs where the costs of these services have been included in educational costs; otherwise, they will be offset against the account to which the expense was charged.

(g) Subsidies Received - Some hospitals which are county, state, or federally owned and operated receive subsidies from these governmental bodies. The subsidies are usually general in nature and are not restricted to payments for a specific element of cost. The hospital may, however, spend all or part of the unrestricted subsidy for approved education purposes. Under such circumstances, the appropriate part of education expense may be included in allowable costs and need not be reduced by the funds received from the governmental body.

On the other hand, a hospital may receive subsidies that are restricted by the federal or local government to further a specific education program of the hospital. Funds so received, regardless of their source, shall be treated as reductions of the educational expense of the hospital.

In some situations, however, state owned hospitals receive appropriations from the state legislature for educational purposes. Such appropriations will not be initially offset against allowable cost. Medicaid, however, reserves the right to consider such appropriation in their determination of reimbursable Medical Education cost.

(h) Part-Time Education - Costs of part-time education for bona fide employees (excluding part-time employees) at properly accredited academic or technical institutions devoted to under-graduate and/or graduate work are allowable costs provided that the activities are related to improving present employee job skills and are not used for activities unrelated to the employee's present job skills or for the purpose of teaching the employee new skills.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986.

Rule No. 560-X-23-.06 Research Costs

(1) Costs incurred for research purposes, over and above usual patient care, are not includable in allowable costs.

The term "research" means a systematic, intensive study directed toward gaining a better scientific knowledge of diagnosing, treating, curing, and/or preventing mental or physical disease, including injury, deformity, relief of pain, and the improvement or preservation of health. The term "usual patient care" is used to mean items and services ordinarily used to treat patients by a hospital. These services, which must be under the supervision of a physician, may be diagnostic, therapeutic, rehabilitative, medical, psychiatric, skilled nursing services, etc. If research is conducted in conjunction with or as a part of the care of patients, the costs of "usual patient care" are reimbursable to the extent that they are not met by research funds.

"Extraordinary patient care," which is not reimbursable and which is represented by additional patient care days and additional ancillary charges that are identified as "non-Medicaid" in patient care cost centers, is care rendered to research patients that is not medically necessary, reasonable, or ordinarily furnished to patients by hospitals.

(2) Accounting for Research - A separate research cost center, which must be used to accumulate all direct and indirect costs, must be established in the hospital's records. "Usual patient care" costs incurred in conjunction with the research must be specifically identified on a special worksheet in those situations where a portion of the research funds is applicable to usual patient care costs. Hospitals must maintain statistics on research patients for each

project to identify the patient days and ancillary charges applicable to the usual patient care furnished.

(3) Offset of Research Funds Against Costs - The portion of research funds designated for "usual patient care" must be used to offset the costs of the applicable patient care cost centers, to the extent of the usual patient care costs incurred for such research. This offset must be shown on a supplemental worksheet after cost finding. The offset, however, is limited to the amount of the usual patient care costs of each patient care cost center incurred in conjunction with the research.

If the research funds applicable to the costs of usual patient care equal or exceed the related usual patient care costs, hospitals will not be reimbursed for any of these costs. Accordingly, the related patient days and ancillary charges must be excluded from the Medicaid statistics and total statistics used in apportioning costs. If the offset is less than total, the research funds will be used to reduce the costs of the routine and ancillary services and the related patient days and ancillary charges will be excluded from the Medicaid statistics and total statistics used in apportioning costs to Medicaid. The portion of the research funds applicable to the costs of the research cost center must be offset against the costs of the research cost center or against allowable hospital costs.

(4) Administrative and Operational Studies - Studies and other related activities designed to improve a hospital's administrative and operational efficiency are not considered to be research costs. Rather, they are includable as allowable administrative costs.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986.

Rule No. 560-X-23-.07 Grants, Gifts, Private Donations or the Income from Such Items, and Income from Endowments

Unrestricted grants, gifts, private donations or the income from such items, and income from endowments should not be deducted from operating costs in computing reimbursable cost. Grants, gifts, private donations, or the income from such items, or endowment income designated by a donor for paying specific operating costs should be deducted from the particular operating cost or group of costs.

(1) Unrestricted Grants, Gifts, Private Donations or the Income from Such Items, and Income from Endowments

Unrestricted grants, gifts, private donations or the income from such items, and income from endowments are funds, cash or otherwise donated to a hospital without restriction as to their use and not commingled with restricted funds.

Unrestricted contributions are not deducted from costs in computing allowable costs. These funds are considered the property of the hospital to be used as it deems appropriate. Unrestricted income from such grants, gifts and endowments may be offset in accordance with other provisions of this Chapter.

(2) Restricted Grants, Gifts, Private Donations or the Income from Such Items, and Income from Endowments

Restricted or designated grants, gifts, private donations or the income from such items, and income from endowments are funds, cash or other- wise, which must be used only for a specific purpose designated by the donor. This

does not refer to unrestricted grants, gifts, private donations or the income from such items, or income from endowments which have been restricted for a specific purpose by the hospital.

Restricted contributions which are designated by the donor for paying certain hospital operating costs, or group of costs, or costs of specific groups of patients, are to be deducted from the designated costs or group of costs. Where the cost or group(s) of costs designated covers services rendered to all patients, including Medicaid recipients, operating costs applicable to all patients are reduced by the amount of the restricted grants, gifts, or income from endowments, thus resulting in a reduction of allowable costs.

(3) Period in Which Funds are Deemed Used

The terms of the contribution may specifically state the period of time during which the funds are to be applied. Where such specific periods of time are not provided, restricted contributions are deemed to be used in the reporting period in which the gift is received, to the extent that applicable costs are incurred after the date of the gift. Restricted contributions not used in the reporting period in which they were received are carried over into the following period, or periods, and used for their designated purpose.

(4) Transfer of Funds to a Hospital by Another Component of the Same Entity

Whether or not they are characterized as a "grant" or a "gift," funds transferred to a hospital from another component of the same organizational entity, e.g., from a university to a university hospital, or from a State agency to a State university hospital, or from a city or county government to a city or county hospital, are not considered a grant or gift for Medicaid reimbursement purposes, but rather an internal transaction amounting only to self-financing of the entity's own component operations, thus having no effect on the hospital's allowable costs. This rule does not apply to educational subsidies or appropriations as described in sub-paragraph (1)(g) of Rule No. 560-X-23-.05.

(5) Donations of Produce or Other Supplies

Donations of produce or supplies are restricted gifts. The hospital may not impute a cost for the value of such donations and include the imputed cost in allowable costs. If an imputed cost for the value of the donation has been included in the hospital's cost, the amount included is deleted in determining allowable costs.

(6) Donation of the Use of Space

A hospital may receive a donation of the use of space owned by another organization. In such case, the hospital may not impute a cost for the value of the use of the space and include the imputed cost in allowable costs.

If the hospital and the donor organization are both part of another entity, such as units of a State or county government, the costs related to the donated space are includable in the allowable costs of the hospital. Such related costs would include depreciation, costs of janitorial services, maintenance, repairs, etc.

(7) Donation of Services

Donations of services are considered to be restricted gifts. The hospital may not impute a cost for the value of such donations and include the imputed cost in allowable costs.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986.

Rule No. 560-X-23-.08 Value of Services of Unpaid Workers

The value of services performed by nonpaid workers who work more than 20 hours per week in various full-time positions is allowable in reimbursable costs as an operating expense if these full-time positions would normally be occupied by paid personnel of hospitals not operated by or related to religious orders. Such amounts must be identifiable in the records of the institutions as a legal obligation, which is actually paid. Also, the nonpaid workers must be members of organizations under arrangements with the hospital for which such services are rendered without direct remuneration (salaries or wages and/or gifts) to the nonpaid workers by either organization. The value allowed cannot exceed the amount per individual allowed for paid employees who perform similar services at similar facilities operating under similar economic, social, and governmental conditions.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986.

Rule No. 560-X-23-.09 Purchase Discounts and Allowances, Recoveries, and Refunds of Expenses

(1) Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds for previous expense payments are reductions of the related expense.

(a) Purchase Discounts - include cash, trade and quantity discounts (see definitions of these latter terms below). Hospitals are expected and encouraged to take advantage of available discounts.

(b) Cash Discounts - are reductions granted for the settlement of debts within a stipulated period before they become due.

(c) Trade Discounts - are reductions from list prices granted to a class of customers before consideration of credit terms.

(d) Quantity Discounts - are reductions from list prices granted because of the size of individual or aggregate purchase transactions.

(e) Allowances - are reductions granted or accepted by the creditor for damage, delay, shortage, imperfection or other cause, excluding discounts and refunds.

(f) Refunds - are amounts paid back by the vendor generally in recognition of damaged shipments, overpayments, or returned purchases.

(g) Rebates - represent refunds of a part of the cost of goods or services. A rebate is commonly based on the total amount purchased from a supplier. It differs from a quantity discount in that it is based on the value of purchases, whereas quantity discounts are generally based on the quantity purchased.

(h) Recoveries - revenues from the resale or scrapping of inventories.

Examples of such recoveries of cost include, but are not limited to, the following:

1. Silver Recoveries
2. Medical Record Transcript Fees
3. Cot Rentals
4. Outside Sales of Medical Supplies
5. Outside Sales of Drugs
6. Surplus Sales of Supplies, Equipment, etc.
7. Guest Meal Services Income
8. Miscellaneous Income
9. Recoveries or Indemnities on Losses (i.e.,

insurance proceeds)
10. Cash Contributions and Donations Designated by a Donor for Paying Specific Operating Costs

(2) Accounting Treatment - Discounts, allowances, refunds, and rebates are not to be considered a form of income. Rather, they shall be used to reduce the specific costs to which they apply in the accounting period in which the purchase occurs.

Where the purchase occurs in one accounting period and the related allowance or refund is not received until the subsequent period, where possible, an accrual in the initial period shall be made of the amount if it is significant, and cost correspondingly reduced. However, if this cannot be readily accomplished, such amounts may be used to reduce comparable expenses in the period in which they are received.

Rebates in the form of cash payments based on the total value of purchases in one accounting period are not generally received until the subsequent accounting period. Where the amount of the rebate can be determined, it shall be accrued in the initial period and costs for that period correspondingly reduced. A reasonable effort should be made to accrue accurate amounts for allowances and rebates which will be received after the books have been closed. The difference between the accrual and the actual amount received may then be entered in the period in which it is actually received. Where a number of cost centers have received numerous charges from purchases, a rebate in recognition of the total of such purchases shall be credited to these cost centers based on an equitable method of allocation.

Where a discount, allowance, refund, rebate or recovery is received on supplies or services, the cost of which is apportioned under the Medicaid program, it must be used to reduce the total cost of the goods or services for all patients without regard to whether it is designated for use by all patients or by a specific group or category of patients.

(3) Rebates to Hospital Owners or Officials - Where an owner or official of a hospital receives money, goods, or services for his personal use directly from a vendor, as a result of the hospital's purchases from the vendor, the value he receives constitutes a type of refund or rebate and should be applied as a reduction of the hospital's costs for goods or services purchased from the vendor.

(4) Contributions by Vendors - Payments to a hospital by its vendors shall be considered discounts, refunds, or rebates in determining allowable costs under the program, even though these payments may be treated as "contributions" or "unrestricted grants" by the hospital and the vendor.

However, such payments may represent a true donation or grant; for example, when they are made by a vendor in response to building or other fund raising campaigns in which community-wide contributions are solicited, or they are in addition to discounts, refunds, or rebates which have been customarily allowed under arrangements between the hospital and the vendor, or the volume or value of purchases is so nominal that no relationship to the contribution can be inferred, or the contributor is not engaged in business with the hospital or a facility related to the hospital, then the payments may be considered unrestricted donations.

(5) Rebates in Central Purchasing Activities - Where the purchasing function for a hospital is performed by a central unit or organization, all discounts, allowances, refunds and rebates should be credited to the costs of the hospital.

(6) Reduction of Cost Through Court Decision, Settlement, or Other Legal Action

Monetary damages received by a hospital as a result of a court decision, settlement, legal action, or other claim for damages, shall be considered reductions of current costs if they represent recoveries of previously allowed costs, including legal fees incurred relating to the litigation.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986.

Rule No. 560-X-23-.10 Compensation of Owners and Individuals with a Control Interest

(1) Reasonable compensation for the services of owners shall be an allowable cost, provided the services are actually performed in a necessary function and rendered in connection with patient care. Services which are not related to either direct or indirect patient care (e.g., those primarily for the purpose of managing or improving the owner's financial investment) shall not be recognized as an allowable cost.

(a) Owner - Owners are persons who have an ownership or control interest as defined in Rule No. 560-X-23-.11, Cost to Related Organizations.

(b) Reasonableness - Reasonableness shall require that the compensation be such an amount as would ordinarily be paid for comparable services by comparable institutions, depending upon the facts and circumstances of each case. Reasonable compensation shall be limited to the fair market value of services rendered by the owner in connection with patient care. Fair market value is the value determined by the supply and demand factors of the open market.

(c) Necessary - The requirement that the function be necessary means that had the owner not rendered the services, the institution would have had to employ another person to perform them. The services must be pertinent to the operation and sound conduct of the institution.

(2) Compensation - Sole Proprietorships and Partnerships - The allowable cost of compensation for the services of sole proprietors and partners is the reasonable value of the services rendered, regardless of whether profits of the business are actually distributed.

(3) Compensation Corporations - For purposes of determining whether the total compensation paid to an owner is reasonable, compensation as defined herein shall mean remuneration paid to an owner regardless of the form in which it is paid. Owner's compensation shall include non-taxable fringe benefits and taxable income reported as such to the Internal Revenue Service and/or other taxing authorities. Forms of compensation not included in the previously mentioned categories shall not be included in allowable cost.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986.

Rule No. 560-X-23-.11 Cost to Related Organizations

(1) Costs applicable to services, facilities, and supplies furnished to the hospital by organizations related to the hospital by common ownership or control

are includable in the allowable cost of the hospital at the cost to the related organization. However, such costs must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. Accordingly, the rule of the lower of the cost or fair market value shall be applicable in this instance for cost reimbursement purposes.

(a) Definitions

1. Related to the hospital means that the hospital, to a significant extent, is associated or affiliated with, has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

2. Common ownership exists when an individual (or an organization) possesses significant ownership or equity in the hospital and the institution or organization serving the hospital.

3. Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(b) Determination of Ownership or Control

In determining whether a hospital is related to a supplying organization, the tests of common ownership and control shall be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. The existence of an immediate family relationship shall create an irrebuttable presumption of relatedness through control or attribution of ownership or equity interests.

1. Common Ownership Rule

A determination as to whether an individual or organization possesses enough ownership or equity in the hospital and the supplying organization, for the organization to be considered related by common ownership shall be made on the basis of the facts and circumstances in each case.

2. Control Rule

The term "control" includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise.

The facts and circumstances in each case must be examined to ascertain whether legal or effective control does, in fact, exist. Since a determination reached in a specific case represents a conclusion based on the entire body of facts and circumstances involved, such determination should not be used as a precedent in other cases unless the facts and circumstances are substantially the same.

(2) Determination of a Related Organization's Costs

(a) The related organization's costs shall include all reasonable costs, direct and indirect, incurred in the furnishing of services, facilities, and supplies to the hospital. The intent is to treat the costs incurred by the supplier as if they were incurred by the hospital itself. Therefore, if a cost would be either allowable or unallowable if incurred by the hospital itself, it would be similarly either allowable or unallowable to the related organization.

The hospital must make available to Medicaid, when requested, adequate documentation to support the costs incurred by the related organization. This shall be applicable for all related organizations as such are defined, implicitly or explicitly, in this Chapter.

(b) Exception to the Related Organization Principle

An exception is provided to the general rule if the hospital demonstrates that the following criteria have been met:

1. The supplying organization is a bona fide separate organization.

2. Eighty percent or more of the supplying organization's business activity of the type carried on with the hospital is transacted with non-related parties in an open competitive market and charges to the hospital are no more than the charges made to others.

Where both conditions of this exception are met, the charges by the supplier to the hospital are allowable as costs.

(c) Special Applications

1. Contracts Creating Relationship - If a hospital and a supplying organization are not related before the execution of a contract, but common ownership or control is created at the time of execution by any means, the contract shall be treated as having been made between related organizations.

2. Termination of Relationship - If a hospital and a supplier are related by common ownership or control at the time of executing a supply contract, the hospital's allowable costs shall be governed by the related organization principle throughout the full term of the supply contract, even if the common ownership or control terminates before the end of the contract.

3. Purchase of Facilities from Related Organizations - Where a facility is purchased from an organization related to the purchaser by common ownership or control, or where a facility, through purchase, converts from a proprietary to a nonprofit status and the buyer and seller entities are related by common ownership or control, the purchaser's basis for depreciation shall not exceed the seller's basis, less accumulated depreciation, recognized under the program.

4. Shared-Services Organizations - A group of hospitals may create a supplier organization by various means which generally include a pooling of hospital resources. These shared-services organizations are to be treated in the same manner as any other supplier. However, in determining if a relationship exists, the ownership or control interest must be viewed on an individual hospital basis. For example, if an individual hospital's interest, considering its individual ownership and/or control interest, in the shared services organization is insignificant when compared to the interests of the entire group, then that hospital is not related to the shared-services organization. This assumes that the hospitals are otherwise unrelated. For example, if all of the hospital members of the shared-services organization are wholly owned subsidiaries of the same parent organization, a relationship exists, even though any one individual hospital's interest in the shared-services organization is insignificant.

(d) Special Purpose Organizations

1. A hospital may establish a separate, special purpose organization to conduct certain of the hospital's patient-care-related or nonpatient-care-related activities (e.g., a development foundation for the hospital's fund raising activity). Often, the hospital does not own the special purpose organization (e.g., a nonprofit, nonstock-issuing corporation) and has no common governing body membership. However, such a special purpose organization is considered to be related to a hospital if:

(i) The hospital controls the special purpose organization through contracts or other legal documents that give the hospital the authority to direct the special purpose organization's activities, management, and policies; or

(ii) The hospital is, for all practical purposes, the sole beneficiary of a special purpose organization's activities. The hospital should be considered the special purpose organization's sole beneficiary if one or more of the three following circumstances exist:

(I) A special purpose organization has solicited funds in the name of and with the expressed or implied approval of the hospital, and substantially all the funds solicited by the organization were intended by

the contributor or were otherwise required to be transferred to the hospital or used at its discretion or direction;

(II) The hospital has transferred some of its resources to a special purpose organization, substantially all of its resources for the hospital's benefit; or

(III) The hospital has assigned certain of its functions (such as the operation of a dormitory) to a special purpose organization which operates primarily for the benefit of the hospital.

(IV) Shared Employees or Any Other Costs. See Rule No. 560-X-23-.13(1)(d)23

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986.

Rule No. 560-X-23-.12 Computation of Return on Equity Capital

(1) An allowance of a reasonable return on equity capital invested and used in the provision of patient care is includable as an element of the reasonable cost of covered services furnished to recipients by proprietary hospitals only. The amount allowable on an annual basis is determined by applying to the hospital's equity, the Medicaid return on equity capital rate. This rate shall be a percentage equal to the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the hospital's reporting period or portion thereof covered under the program. Such allowance shall be eliminated over a three year period beginning with the 7/1/88 rate period. Payment will be 75% of the amount (as normally calculated within this rule); 7/1/89, 50%; 7/1/90, 25%, and zero thereafter.

(a) Base for Computing Return - The base amount of equity capital to be used for computing the allowable return is the average investment of the owners during the reporting period. Investment in facilities is recognized on the basis of the historical cost or other basis used for depreciation and other cost purposes under the Medicaid program. The equity capital in each month is determined and an average of the monthly amounts computed. This is the average equity capital in use during the period. Where the period is less than a year, a proportionate amount of the return is allowable (e.g., seven month period - only 7/12th of the return is allowable). In any month in which there is a net worth of less than zero (negative equity), the equity for that month shall be the negative amount. However, average equity for the year shall not be less than zero.

(b) Equity Capital - The term "equity capital" means the net worth of a hospital as determined by generally accepted accounting principles. However, this shall exclude:

1. Assets and liabilities not related to patient care, and
2. Assets and liabilities adjusted or limited by other provisions of this Chapter.

Liabilities to pay income taxes are included in the computation of equity capital.

(c) Loans From Owners or Between Related Organizations - Debts representing loans from partners, stockholders, or related organizations on which interest payments are not allowable, are excluded from the equity capital computation.

(d) Receivables Created by Loans Between Related Organizations - Receivables created by loans or other transfers of assets between related organizations are excluded from the equity capital computation.

(e) Assets Leased From Related Organizations - Generally, reimbursement to any hospital leasing facilities or equipment from a "related organization" is limited to what the costs of ownership of the leased facilities would be (depreciation, taxes, interest expenses, etc.) if the hospital owned the facilities. Therefore, the owners' equity in the leased assets is includable in the equity capital of a proprietary hospital.

(f) Assets Acquired Under a Lease Purchase Agreement from an Organization Not Related to the Hospital - The value of an asset which is leased from a nonrelated organization and treated as a virtual purchase is to be included in determining equity capital by computing the cost of the asset less accumulated depreciation and/or related debt.

(g) Excess of Purchase Price Over Allowable Cost - For facilities or tangible assets, the excess of the purchase price paid for a facility or asset over (1) the historical cost of the tangible assets, or (2) the cost basis of the tangible assets, whichever is applicable, is not includable in the computation of equity capital. Loans made to finance such excess portion of the cost of such acquisitions are similarly not includable in the computation of equity capital.

(h) Goodwill - Goodwill purchased in an acquisition of an existing organization or internally generated is not includable in the hospital's equity capital.

(i) Gifts and Grants - Gifts and grants which are unrestricted as to use are includable in the hospital's equity capital. However, restricted gifts and grants are not includable in the hospital's equity capital.

(j) Invested Funds - Funds invested for more than six consecutive months are not includable in the hospital's equity capital. Funds invested in the hospital's funded depreciation account are also excluded.

(k) Assets Held in Anticipation of Expansion - Land, buildings, or other assets acquired in anticipation of expansion are not includable in equity capital as long as they are not being used in the operation or maintenance of patient care activities. Liabilities related to these assets will also be excluded. Construction-in-process and liabilities related to such construction are not includable in equity capital.

(l) Cash Surrender Value of Life Insurance - Cash surrender value of life insurance, where the hospital is designated as the beneficiary, is excluded from equity capital.

(m) Prepaid Life Insurance Premiums - Prepaid premiums on life insurance a hospital carries on officers and key employees, where the hospital is designated as the beneficiary, are not includable in computing equity capital.

(n) Noncompetition Agreements - In the sale of an ongoing facility, the purchaser might pay the seller a specific amount for an agreement not to compete, generally for a stated number of years. The costs of such agreements are not included in the hospital's equity capital.

(o) Self-Insurance Reserve Fund - Where a hospital maintains a self-insurance program in lieu of purchasing conventional insurance, the funds in the self-insurance reserve fund must be set aside in a segregated account to cover possible losses and not used to provide patient care. Therefore, the amount deposited in the fund and the earnings on the self-insurance reserve remaining in the fund are not included in equity capital.

(2) Home Office Equity Capital

Where a hospital that is a member of a chain organization receives services from the home office and the costs of such services are reimbursable, the hospital must include in its equity capital computation its proportionate share of the equity capital of the home office which is related to patient care. The equity capital of the home office is generally computed in the same manner

as it is for hospitals. However, where a negative amount is shown in the home office equity capital balance for any month, the negative amount is included for that month in the hospital's equity capital balance to determine the hospital's equity capital.

Assets and liabilities on the records and includable in the equity capital of the home office which are directly attributable to a hospital in the chain must be allocated directly to that hospital or entity. The remaining home office equity capital or "pooled" equity capital, must be allocated on the basis of the ratio that the portion of home office costs allocated to each hospital or other entity bears to total home office costs.

Medicaid must be furnished with a detailed home office cost statement as the basis for reimbursing a hospital for home office equity capital.

Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986. Effective date of this amendment May 25, 1988.

Rule No. 560-X-23-.13 Cost Related to Patient Care

(1) All payments to hospitals must be based on the reasonable cost of services, related to the care of Medicaid recipients, and acquired under the prudent buyer concept. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost.

(a) Prudent Buyer - Under the prudent buyer concept, it is expected that a hospital will seek to minimize costs and that costs will not exceed what a prudent, cost conscious, and reasonable buyer would pay for services or products of a similar nature under similar circumstances. If costs are determined to exceed the level that such a buyer would incur, the excess costs are not reimbursable under the program in the absence of clear evidence that the higher costs were unavoidable.

(b) Costs Not Related to Patient Care - Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing Medicaid reimbursable costs.

(c) Unallowable Costs Related to Patient Care - Such costs include, but are not limited to, the following:

1. Private-Duty Personnel

The costs of private-duty nurses and other private-duty attendants are not included in allowable costs.

2. Luxury Items or Services

(i) General - Where hospital operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.

(ii) Definitions - Luxury items or services are those that are substantially in excess of or more expensive than the usual items or services rendered within a hospital's operation to the majority of patients who are furnished semi-private accommodations. Consequently, most hospitals charge higher rates for these services to their respective patients.

(iii) Application - Once it has been determined that luxury items or services have been furnished, allowable costs must be reduced by the difference between the costs of luxury items or services actually furnished and the reasonable costs of the usual less expensive items or services furnished by a hospital to the majority of its patients. Where patients request luxury items or services, the hospital may charge the patients for the excess costs involved. The disallowance will be accomplished in the cost apportionment

process in which Medicaid will reimburse for routine and special care services based on the ratio of Medicaid allowable accommodation charges to total accommodation charges.

3. Dental Services - Compensation paid to a dentist for services to or for an individual patient are not allowable hospital costs and are nonreimbursable to the hospital. The costs, however, of consultative services furnished by an advisory dentist to a hospital are allowable costs, subject to the usual rules concerning reasonable costs incurred by hospitals. Consultative services may include, for example, participating in the staff development program for nursing and other personnel and recommending policies relating to oral hygiene or dietary matters.

4. Cost of Hospital-Based Physicians - Remuneration to hospital-based physicians for direct patient services are not allowable. However, the reasonable cost of physician services related to the overall patient population or the direct supervision of hospital personnel is allowable.

(d) Unallowable Costs Not Related to Patient Care - Such costs include, but are not limited to the following:

1. Cost of Telephone, Television and Radio

(i) General - The full costs of items or services such as telephone, television, and radio which are located in patient accommodations and which are furnished solely for the personal comfort of the patients are excluded from allowable costs of hospitals under the Medicaid program. Full costs include costs both directly associated with personal comfort items or services plus an appropriate share of indirect costs. The costs of television and radio services are includable in allowable costs where furnished to the general patient population in areas of hospitals other than patient accommodations.

The costs of a nurse-patient communication system that has no capability for other than communications between patient and nurse (or other facility employees) is includable in allowable costs. Similarly, costs of closed circuit television monitoring systems used by hospitals for surveillance of patients or for security, teaching, or demonstration programs which serve purposes of patient care or which are otherwise needed for the hospital's operations and have no capability beyond these stated purposes are includable in allowable costs.

(ii) Combination Purpose Systems - Where communication systems serve both allowable and unallowable functions, the hospital must exclude from allowable cost that portion of the expense related to the unallowable function.

2. Reimbursement of Meals for Other than Hospital Personnel

The cost of meals for other than hospital personnel, including staff physicians not on salary, whether served in a cafeteria, coffee shop, canteen, etc., is unallowable. Hospitals must maintain adequate cost data in order to determine the cost of these meals. Where the hospital can demonstrate that the revenue derived from the sale of meals for other than hospital personnel approximates their cost, the offset of revenues against expense related to those meals will be deemed appropriate.

3. Noncompetition Agreement Costs

Amounts paid a seller of a facility to acquire an agreement not to compete are unallowable.

4. Parking Lot Costs

(i) General - The costs incurred for hospital-owned or rented parking facilities, parking lots, and/or garages are allowable costs provided the parking facilities are for the use of patients, employees, and other hospital purposes. Examples of allowable costs for a hospital-owned parking facility include depreciation on the surface and structure (excluding land), interest on related loans, and other operating expenses. Costs related

to the preparation of the land, such as demolition of existing structures, clearing, and grading costs, should be added to the cost of the land and are unallowable.

The allowable costs for hospital-rented parking facilities are limited to the reasonable rental which the hospital has a legal obligation to pay.

(ii) Treatment of Parking Lot Revenue - Where a hospital receives no revenue from parking lots, the allowable costs are reimbursed, subject to apportionment. Where, however, a hospital elects to charge a fee for the use of these facilities, such revenue is offset against expenses up to the amount of parking lot expense.

5. Advertising Costs - General

The allowability of advertising costs depends on whether they are appropriate and helpful in developing, maintaining, and furnishing covered services to Medicaid recipients. In determining the allowability of these costs, Medicaid will consider the facts and circumstances of each situation as well as the amounts which would ordinarily be paid for comparable services by comparable institutions. To be allowable, such costs must be common and accepted in the field of the hospital's activity.

(i) Allowable Advertising Costs - Advertising costs incurred in connection with the hospital's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. Examples of information which may be presented through allowable advertising include visiting hours information, conduct of management-employee relations, etc. Costs connected with fund raising are not included in this category.

Costs of advertising for the purpose of recruiting medical, paramedical, administrative and clerical personnel are allowable if the personnel would be involved in Medicaid-covered patient care activities or in the development and maintenance of the facility.

Costs of advertising for procurement of items or services related to patient care and for sale or disposition of surplus or scrap material are treated as adjustments of the purchase or selling price.

Costs of advertising incurred in connection with obtaining bids for construction or renovation of the hospital's facilities should be included in the capitalized cost of the asset.

Costs of advertising incurred in connection with bond issues for which the proceeds are designated for purposes related to patient care, i.e., construction of new facilities or improvements to existing facilities, should be included in "bond expenses" and prorated over the life of the bonds.

Costs of informational listings of hospitals in a telephone directory, including the "yellow pages," or in a directory of similar facilities in a given area are allowable if the listings are consistent with practices that are common and accepted in the industry. Further, telephone directory advertising shall be limited to the cost of a one-half page in one telephone directory serving the hospital's primary service area.

Costs of advertising for any purpose not specified above or not excluded below may be allowable if they are related to patient care and are reasonable. The burden of proof shall be upon the hospital to show that these factors are present.

Costs for allowable advertising must be supported by adequate documentation. Such documentation should include transcripts of radio and television commercials, copies of newspaper and magazine advertisements, copies of advertising agency contracts, etc.

(ii) Unallowable Advertising Costs - Costs of fund-raising, including advertising, promotional, or publicity costs, are not allowable.

Costs of advertising of a general nature designed to invite physicians to utilize a hospital's facilities in their capacity as independent practitioners are not allowable.

Costs of advertising incurred in connection with the issuance of a hospital's own stock, or the sale of stock held by the hospital in another corporation, are considered as reductions in the proceeds from the sale and, therefore, are not allowable.

Costs of advertising to the general public which seek to increase patient utilization of the hospital's facilities are not allowable. Situations may occur where advertising which appears to be in the nature of the hospital's public relations activity is, in fact, an effort to attract more patients. An analysis by Medicaid of the advertising and its distribution may then be necessary to determine the specific objective.

6. Membership Costs - General

Costs incurred due to a hospital's membership in various organizations are customarily considered to be ordinary operating costs.

Some of those organizations promote objectives in the hospital's field of health care activity. Others have purposes or functions which bear little or no relationship to this activity. In order to determine for Medicaid purposes the allowability of costs incurred as a result of membership in various organizations, memberships have been categorized into three basic groups: (1) professional, technical or business related; (2) civic; and (3) social, fraternal, and other.

7. Professional, Technical, or Business Related Organizations

The Medicaid Program classifies organizations in this category if their functions and purposes can be reasonably related to the development and operation of patient care facilities and programs or to the rendering of patient care services. Memberships in these organizations, while not restricted to hospitals, are generally comprised of hospitals, hospital personnel, or others who are involved or interested in patient care activities.

Costs of memberships in such organizations are allowable for purposes of Medicaid reimbursement. These costs include initiation fees, dues, special assessments, and subscriptions to professional, technical or business related periodicals. Also included are costs related to meetings and conferences, such as meals, transportation, registration fees and other costs incidental to those functions, when the primary purpose of such meetings and conferences is the dissemination of information for the advancement of patient care or efficient and economic operation of the facility.

Travel costs incurred outside of the U.S. and its territories are not allowable.

(i) Civic Organizations - These organizations function for the purpose of implementing civic objectives. Reasonable costs of initiation fees, dues, special assessments, and subscriptions to periodicals of civic organizations are allowable. Also allowable are those reasonable costs related to local meetings and conferences, such as meals, transportation, registration fees, and other costs incidental to these functions when the primary purpose of such meetings and conferences is the promotion of civic objectives.

(ii) Social, Fraternal, and Other Organizations - Generally, these organizations concern themselves with activities unrelated to their members' professional or business activities. Their objectives and functions cannot be considered reasonably related to the care of patients. Consequently, hospital costs incurred in connection with memberships in social, fraternal, and other organizations are not allowable.

8. Political Contributions

Contributions made directly to candidates for or incumbents of political offices are not allowable. Also, contributions made indirectly through other individuals, committees, associations or other organizations for campaign or other political purposes are not allowable.

9. Taxes

(i) Taxes Not Allowable as Costs - Certain taxes which are levied on hospitals are not allowable costs. These taxes are:

(I) Federal and state income taxes, including any interest or penalties paid thereon.

(II) Taxes from which exemptions are available to the hospital.

(III) Special assessments on land which represent capital improvements such as sewers, water lines, and pavements. (These should be capitalized and depreciated over their estimated useful lives.)

(IV) Taxes on property which is not used in the rendering of covered services.

(V) Penalties and late charges on allowable taxes. (These are imprudent and therefore unallowable.)

(VI) Privilege taxes on disproportionate share hospitals.

10. Ambulance Service

Any costs associated with ambulance service costs are not allowable for Medicaid inpatient hospital reimbursement purposes. Such unallowable costs include, but are not limited to, all costs associated with the vehicle, operation of the vehicle, transportation between hospitals, medical and paramedical attendants, and the costs of all medical treatment rendered in the ambulance while in route. Some of these unallowable costs are considered allowable under other Medicaid programs. For example, a physician may bill under the physician program, ground ambulances are covered under the Medicaid transportation program. However, the Medicaid transportation program does not cover air ambulances nor does any other Alabama Medicaid program.

11. Costs Relating to Union Activities

Costs incurred for activities directly related to influencing employees regarding unionization are not allowable. Reasonable expenses incurred by a hospital for collective bargaining and related activities, such as contract negotiations and any procedures flowing from enforcement of contract terms, are allowable.

12. Billing Costs

Where a hospital derives revenue from charges on delinquent accounts receivable, the actual cash received from the additional charge in excess of the original balance due must be used as a deduction from allowable administrative and general costs. The hospital may not remove the related costs of preparing, billing and collecting all accounts receivable balances, or costs of only those accounts which generated the income, from allowable costs to avoid this income offset requirement.

13. Life Insurance Premiums

Premiums for life insurance coverage which unduly favors officers and key employees are not allowable.

14. Start-Up Costs

Costs incurred prior to a hospital (or wing or portion thereof) opening are considered start-up costs. These must be capitalized and amortized over a 60-month period commencing immediately after the hospital or area has been placed in service for patient care. Amortization expenses of such start-up costs shall be allowable to the extent that the expenses incurred would have been allowable if the facility had been operational.

15. Deferred Compensation and Pension Plans

The costs of qualified pension plans and deferred compensation plans, as defined by IRS regulations, are allowable if the following requirements are satisfied. The plan must be a formal, written agreement made known to all eligible employees. In addition, the plan must provide for (1) an actuarially sound method for calculating the contributions to the fund, (2) the funding and protection of the plan's assets, (3) the specific conditions under which the benefits become vested, (4) the basis for computing the amount of benefits to be paid, (5) allowable cost will not exceed seven and one-half percent (7 1/2%) of allowable gross salaries, and (6) must be expected to continue despite normal fluctuations in the hospital's business.

16. Home Office Costs-Chain Operations

The home office of a chain organization is not a hospital in itself, and, therefore, its costs cannot be directly reimbursed by the Medicaid program. The relationship of the home office to the Program is that of a related organization to participating hospitals. Home offices usually furnish central managerial and administrative services (i.e., accounting, purchasing, and personnel services) to hospitals in the chain. To the extent that such services are related to patient care, the reasonable costs of these services are reimbursable as part of the hospital's costs. In many cases, the home office charges hospitals in the chain a management fee for the services it furnishes. Since management fees between related organizations are generally not allowable, the fees must be excluded from allowable costs. However, if the fees are disallowed, the home office's reasonable costs for providing the services that are related to patient care constitute allowable costs of the hospital.

The general limitation on the allowability of home office costs is as follows: where a hospital is furnished services, etc., by an organization related to it by common ownership or control (i.e., the hospital's home office), the "related organization" principle applies. Thus, reimbursement to the hospital is limited to the lower of: (1) allowable costs properly allocated to the hospital, or (2) the price for comparable services, etc. (taking account of the benefits of effective purchasing that would accrue to each hospital because of purchasing on a chain-wide basis).

Medicaid must be furnished with a detailed home office cost report as the basis for reimbursing a hospital for home office costs.

17. Capital Planning Costs

Generally, a hospital incurs capital planning costs when it makes plans for expansion, renovation, or relocation. Such costs, including feasibility and engineering studies, shall become part of the historical cost of the completed facility. Capital planning costs are recognized under Medicaid if (1) they are reasonable and prudent, and (2) they become part of the related completed facility's historical cost. Planning costs will be included in allowable cost providing that such cost meet other provisions contained in the regulations concerning the allowability of such costs and their relationship to the provisions of covered patient care.

18. Services Governmental Hospitals Receive From Governmental Units

Agencies and departments of state and local governments sometimes furnish hospitals operated by such governments with facilities and services necessary to the operation of the hospitals. These facilities and services include such items as motor pool, legal counsel, procurement, personnel administration, payroll, etc. The costs of such facilities and services are allowable providing they are reasonable, related to patient care, allowable under the regulations, and and allocated on an acceptable basis. Allowable services may also include an allocable share of supportive and supervisory time directly spent in furnishing services to the hospital.

19. Losses From Other Than Sale of Assets

Maintenance of an adequate insurance program to protect against losses, particularly losses threatening the financial stability of a hospital, is a sound and prudent management practice. Accordingly, if a hospital elects not to maintain adequate insurance protection against such losses, the Medicaid program will not indemnify it for its failure to do so. If a hospital is unable to obtain coverage and it sustains losses while it is uninsured, the costs of the losses will be allowable where the hospital can establish the unavailability of the coverage. However, with respect to malpractice and comprehensive general patient liability coverage, if a hospital cannot obtain coverage, it is required to select the self-insurance alternative. A reasonable deductible is allowable for reimbursement purposes. Unusually large deductibles incurred due to the terms of coverage of certain policies can be construed by Medicaid as being tantamount to non-coverage and can therefore be held as imprudent and unallowable.

20. Insurance Costs

Generally, the reasonable costs of the following types of insurance purchased from a commercial carrier or a nonprofit service corporation, if consistent with sound management practice, are allowable: property damage and destruction, liability, consequential loss or indirect loss, and theft insurance. Contributions to a self-insurance program are not allowable costs with the exception of trust funds maintained for malpractice and workers' compensation insurance, and employee health-insurance coverage. Contributions to such allowable self-insurance trust funds must be substantiated by outside, independent actuarial determination. Further, contributions to these self-insurance trusts shall be allowable to the extent of the cost of similar coverage obtained through a commercial carrier or other bona fide insurer in an arms-length transaction. Excess contributions, either above the actuarially-determined funding level or in excess of market prices as heretofore described, shall be unallowable.

21. Legal, Accounting, and Other Professional Fees Associated With the Representation of a Hospital Relating to Reimbursement Controversies with Medicaid

All legal, accounting, and other professional fees associated with representing the hospital in any reimbursement controversy or dispute with the Alabama Medicaid Agency are not allowable. This shall not apply to routine legal, accounting, and other professional fees of the hospital or to fees related to the routine preparation, filing, and certification of the hospital's cost report.

22. Time Limit on Liquidation of Liabilities

All accounts payable or other current liabilities associated with expenses included in allowable cost must be liquidated, satisfied, or otherwise disposed of within one year of the date that the expenses were incurred and included in allowable cost. Expenses related to current accounts payable or other current liabilities not disposed of within one year shall be disallowed.

23. Special Purpose Organizations Which Share Officers or Any Other Employee With the Hospital.

In those instances in which a hospital has established a separate special purpose organization to conduct nonpatient care activities (see Rule No. 560-X-23-.11(b)2.(2)(C)4.(d)) and the hospital and special purpose organization share common officers or any other employees, that portion of salaries or any other expenses paid by the hospital which pertain to operation of the special purpose organization(s) shall not be an allowable cost of the hospital.

24. Acquisition Costs

Feasibility studies, accounting or legal fees, etc., are not reimbursable costs for sales of facilities occurring on or after July 18, 1984,

if such costs have been capitalized and amortized under the program, as a part of the seller's cost, prior to this date.

25. Donations

Donations made by the hospital to a charitable, political, or any other type of organization are unallowable.

26. Collection Agency Fees

Fees charged a hospital by a collection agency under contract to the hospital are allowable as administrative costs of the hospital.

27. Entertainment

Only those reasonable costs associated with social functions which are open to all hospital employees are allowable as entertainment expense.

Authority: State Plan, Attachment 4.19A; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986 and August 10, 1987. Emergency Rule effective October 1, 1991. Effective date of this amendment January 14, 1992. This amendment effective May 13, 1993.

Rule No. 560-X-23-.14 Cost Finding and Apportionment of Medicaid Cost of Medicaid Cost of Services

(1) Principle - Hospitals receiving payment on the basis of reimbursable costs must provide adequate cost data, based on financial and statistical records which can be verified by auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

(2) Adequacy of Cost Information - Cost information as developed by the hospital must be current, accurate, and in sufficient detail to support payments made for services rendered to recipients. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable cost, capable of being audited.

Financial and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting principles, provided that full disclosure of significant changes are made to Medicaid.

(3) Cost Finding Methods - Departments within a hospital are usually divided into two types: (1) those that produce patient care revenue (e.g., routine services, radiology), and (2) those that do not directly generate patient care revenue but are utilized as a service by other departments (e.g., laundry and linen, dietary). The two types of departments are commonly referred to as "revenue-producing cost centers" and "nonrevenue-producing cost centers," respectively.

Although nonrevenue-producing cost centers do not directly produce patient care revenue, they contribute indirectly to patient care revenue by "serving" the revenue-producing centers and other nonrevenue-producing centers. Therefore, for the purpose of proper matching of revenue and expenses, the cost of the revenue-producing centers should include both its direct expenses and its proportionate share of the costs of each nonrevenue-producing center (indirect costs) based on the amount of services received. The process of allocating the cost of a particular nonrevenue-producing center to other nonrevenue-producing centers and revenue-producing centers shall be performed by utilizing statistics

(e.g., pounds of laundry for allocating "laundry and linen" costs, square feet for allocating "depreciation building" costs).

For Medicaid cost reporting purposes, the "single step-down method" of cost allocation shall be used. This method recognizes that services rendered by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers, as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all cost centers which they serve, and which are still not closed under the step-down method, regardless of whether these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers is allocated first. Following the allocation of the cost of the nonrevenue-producing center, that center will be considered closed and no further costs are allocated to that center. This applies even though it may have received some services from a center whose cost is allocated later. Generally, when two centers render service to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

(4) Bases of Allocation Under Step-Down Method - The order of allocation under the single step-down method and the statistical bases which must be used are as follows:

Cost Element Number	Cost Element	Mandatory Statistical Bases
1.	Capital-related costs-buildings and fixtures	a. Square feet
2.	Capital-related costs-movable equipment	a. Dollar value of equipment b. Square feet
3.	Employee health and welfare	a. Gross salaries (See 5(e)(5) of this Section)
4.	Administrative and general	a. Accumulated cost
5.	Plant operations	a. Square feet
6.	Laundry and linen	a. Pounds of laundry
7.	Housekeeping	a. Hours of service b. Square feet
8.	Dietary	a. Meals served*
9.	Nursing administration	a. Direct nursing hours b. Number of employees supervised
10.	Central Sterile	a. Time spent

11.	Central Supply	a.	Costed requisi tions
12.	Pharmacy	a.	Costed requisi tions
13.	Medical records	a.	Time spent
14.	Nursing education	a.	Time spent
15.	Medical education	a.	Assigned time
16.	Paramedical education	a.	Assigned time

* This statistical base includes the number of meals served to hospital patients. If employee meals are allocated to various cost centers, based on actual employee meal counts per cost center or if total employee meals served are allocated on the percentage of full time equivalent employees assigned to each cost center, the inclusion of employee meals is permissible. NOTE: Staff physicians not on salary are not considered hospital employees. Any revenue received from employee meals must be used to offset costs. Meals served to anyone other than hospital patients or hospital employees are to be reported in a non-reimbursable cost center.

(5) Definition of Certain Cost Centers - In order for all hospitals to report expenses under comparable categories, the following cost centers and functions have been defined:

(a) Administrative and General - Administrative and general expenses must include labor and non-labor related costs associated with but not limited to the following categories:

Patient accounting
Data processing
Communications (PBX, Switchboard)
Purchasing, receiving and stores
General accounting
Credit and collections
Personnel and payroll
Social services
Public relations
Chaplain
Planning and development
Volunteer service
Admitting
Working capital loan interest (not related to capital acquisitions)
Cashier
Administrative support services

(b) Employee Health and Welfare

Employee benefits must include:
Statutory payroll taxes
Pension and other deferred compensation plans
Workers' compensation insurance
Group health, life and disability insurance plans
Other non-discriminatory fringe benefits

(c) Central Sterile - This cost center should include the cost of salaries and supplies associated with the sterilization of instruments and supplies for more than one department.

(d) Central Supply - This cost center should include the cost of salaries and supplies associated with the dispensing of both chargeable and nonchargeable medical supplies to more than one department.

(e) Other

1. The cost of security is to be included in plant operations.

2. Travel and employee education are to be included in the cost of the department in which the respective employee works.

3. PRO and utilization review costs shall be included in medical records.

4. Telemetry charges and cost must be classified to the nursing units in which the charge was incurred.

5. Internal allocations on the hospital's books (such as monthly allocations of laundry, utilities, etc.) must be reversed prior to the step-down allocation process. However, employee health and welfare costs may be directly assigned to respective departments in the hospital's accounting records and need not be reversed.

(6) Changing Bases for Allocation Cost Centers or Order In Which Cost Centers are Allocated - When a hospital wishes to change its allocation basis for a particular cost center, or to establish a new cost center not listed herein because it believes the change will result in more appropriate allocations, the hospital must make a written request to Medicaid for approval of the change and submit reasonable justification for such change prior to the beginning of the cost reporting period for which the change is to apply. There shall be no requests granted for changes in the order or sequence of allocation; for the Administrative and General cost center, there shall be no request for changes in basis. Medicaid's approval of a hospital's request will be furnished to the hospital in writing. Where Medicaid approves the hospital's request, the change must be applied to the cost reporting period for which the request was made, and to all subsequent cost reporting periods unless Medicaid approves a subsequent request for change by the hospital. The effective date of the change will be the beginning of the cost reporting period for which the request was made.

(7) Home Office Cost Finding - Home office expenses may include these types of expenses: (1) expenses which apply only to specific hospitals, (2) functional expenses, such as data processing which can be assigned based on statistical studies, and (3) pooled expenses i.e., which are administrative and/or supervisory and can not be directly assigned or allocated on statistical studies.

For Medicaid cost reporting:

(a) Expenses which apply to specific hospitals or entities must be assigned directly.

(b) Functional expenses may be allocated on statistical studies; and

(c) Pooled expenses must be allocated between hospital and non-hospital entities on the basis of accumulated costs and then to hospitals either on accumulated cost or total inpatient days.

(8) Special Care Units - Medicaid shall apply special rules regarding whether a nursing unit will be combined into general routine nursing care or will be segregated as a separate special care unit.

To be considered a special care type unit, the unit must furnish services to critically ill patients. A critically ill patient is defined as a person with a serious illness or injury who requires that special life-saving techniques and equipment be immediately available. The special care type unit furnishes services in life-threatening situations and provides an intensive level of care. (Examples of special care units include, but are not limited to,

intensive care units, trauma units, coronary care units, pulmonary care units, and burn units. Excluded as special care type units are postoperative recovery rooms, postanesthesia recovery rooms, maternity labor rooms, and subintensive or intermediate care units.) The unit must also meet the following conditions:

(a) The unit must be in a hospital.

(b) The unit must be physically and identifiably separate from general routine patient care units, including subintensive or intermediate care units, and ancillary service areas.

Segregation of patients to specific areas, (such as psychiatric, neuropsychiatric, geriatric, pediatric, mental health, rehabilitation, etc.) by type of illness or age does not qualify those areas as special care units for purposes of reimbursement unless all requirements are met.

There cannot be a concurrent sharing of nursing staff between a special care unit and units or areas furnishing different levels or types of care. However, two or more special care units that concurrently share nursing staff can be reimbursed as one combined special care unit if all other criteria in this section are met.

Float nurses (nurses who work in different units on an as-needed basis) can be utilized in the special care unit. If a float nurse works in two different units during the same 8-hour shift, the costs must be allocated to the appropriate units depending upon the time spent in each unit. The hospital must maintain adequate records to support the allocation. If such records are not available, the costs must be allocated to the general routine service cost area.

(c) There must be specific written policies that include criteria for admission to, and discharge from, the unit.

(d) Registered nursing care must be furnished on a continuous 24-hour basis. At least one registered nurse must be present in the unit at all times.

(e) A minimum nurse-patient ratio of one nurse to two patients per patient day must be maintained; i.e., 12 hours of nursing care per patient day. This can be calculated by converting the total number of patient days into patient hours, with this total being divided by the total number of nursing hours. For example, if the total number of patient days is 1,000, the number of patient hours is 24,000. Dividing this by the total number of nursing hours gives the ratio. Included in the calculation of this nurse-patient ratio are registered nurses, licensed vocational nurses, licensed practical nurses, and nursing assistants who provide patient care. Not included are general support personnel such as ward clerks, custodians and housekeeping personnel.

(f) The unit must be equipped with, or have available for immediate use, lifesaving equipment necessary to treat the critically ill patients for which it is designed. This equipment may include, but is not limited to, respiratory and cardiac monitoring equipment, respirators, cardiac defibrillators, and wall or canister oxygen and compressed air.

(9) Limitation of Allocation of Indirect Costs Where Ancillary Services are Furnished Under Arrangements

a. If a hospital furnishes ancillary services to Medicaid patients under arrangements with others and pays the supplier, but simply arranges for such services for non-Medicaid patients and does not pay the non-Medicaid portion of the services, its books will reflect only the cost of the Medicaid portion. In this situation, no indirect costs shall be allocated to the Medicaid portion. Instead, the total indirect costs will be allocated to all other departments so that each of these departments will absorb proportionately those indirect costs which otherwise would have been allocated to the arranged for services. The overhead elimination is accomplished by removing from the statistical bases used for allocation (square feet, hours, etc.) the statistics for the cost center that includes Medicaid-only services purchased under arrangements.

b. There may be situations where Medicare or other third-party payers will pay a supplier directly for services rendered to their beneficiaries while Medicaid and other groups of patients receive such services under arrangements through the hospital. In these cases, since the hospital is not recording all of the costs of services rendered to all patients, the "no overhead allocation" rule must be applied. If Medicaid determines that a hospital is able to "gross up" the costs and charges for services to non-Medicaid patients so that both charges and costs are recorded as if the hospital had provided such services directly, then indirect costs may be applied to the ancillary department.

(10) Distribution of General Service Costs to Nonallowable Cost Areas

Nonallowable cost centers to which general service costs apply should be entered on the appropriate worksheet of the cost report after all other cost centers. General service costs should then be distributed to the nonallowable cost centers in the routine "step-down" process. Where a hospital can demonstrate to Medicaid that the use of the required statistics does not result in an equitable distribution of costs to the nonallowable cost areas, the hospital may apportion general service costs to these areas by either (a) weighting the statistical basis used in allocating the appropriate general service cost, or (b) making appropriate adjustments to costs prior to the step-down process. Nonallowable cost centers include, but are not limited to, (1) gift, flower and coffee shops; (2) hospital-related nursing homes, professional office buildings; (3) (separately certified) nursing units not covered by Medicaid.

(11) Allocation of Interest and Other Expenses Related to Assets

Where the statistical allocation basis for allocation of capital costs of buildings and major movable equipment differs, the hospital must reclassify interest expense and other capital costs (such as property taxes, insurance, and rent) between the two cost centers on some reasonable, logical, and verifiable basis.

Investment income offsettable against capital-related interest expense must bear the same ratio as the distribution of capital-related interest expense.

(12) Apportionment of Cost to the Medicaid Program Based On Revenues

(a) Once the full cost of revenue-producing cost centers is determined through the single step-down cost allocation process, the respective cost of these cost centers to Medicaid recipients is determined as follows:

1. Total costs produced by each individual revenue producing cost center are divided by each center's total revenues to obtain a cost to charge ratio.

2. This cost to charge ratio is then multiplied by the respective Medicaid charges for that cost center.

(b) For this method to be valid, the following criteria concerning total revenues and Medicaid revenues must be met:

1. Revenues must be properly matched against related expenses.

2. Revenues must be consistent and comparable. If discounts and allowances to certain classes of patients or other individuals are reflected in the standard hospital rate schedule rather than being duly recorded on the books as a "deduction from revenues" or other discount, then appropriate adjustments to "gross-up" the revenue basis for the cost center must be made. Grossing up of costs means applying to the non-Medicaid patient services the same schedule of charges used by the servicing entity to bill the hospital for Medicaid patient services. Costs so determined should be added to the costs of services of Medicaid patients. Grossing up of charges means applying the hospital's standard charge structure to the non-Medicaid patient services.

3. For hospitals certified to operate swing beds, the revenues associated with such swing beds shall remain in total hospital revenue for the appropriate cost center. Swing bed ancillary revenues and swing bed routine revenues must be in accordance with the hospital's established swing bed routine rate.

4. For hospitals operating post-hospital extended care services beds, the revenues associated with such beds shall remain in total hospital revenue for the appropriate cost center. Post-hospital revenues must be in accordance with the hospital's established post-hospital extended care services bed rate.

(13) Patient Days

(a) Definition of Patient Days

1. Routine inpatient day - Routine inpatient day means a day of care rendered to any inpatient, other than an inpatient occupying a bassinet for the newborn in the nursery or an inpatient in any special care type inpatient hospital unit.

2. Special care day - Special care day means a day of care rendered to an inpatient in a special care unit.

3. Nursery day - Nursery day means a day of care rendered to an inpatient occupying a bassinet for the newborn in the nursery.

4. Boarder day - Boarder day means a day of care rendered to an inpatient occupying a bassinet for the newborn in the nursery who:

(i) Was delivered outside the hospital and/or

(ii) Remains in the hospital after the mother is discharged.

5. Medicaid inpatient day - For per diem rate calculation purposes, a Medicaid inpatient day means a day of care rendered to a Medicaid recipient for which a per diem rate is received or is due to be received for a covered day.

(b) Medicaid Patient Days

1. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method must be used even if the hospital uses a different definition of a patient day for its statistical or other purposes. Where the patient occupies a bed in more than one patient care area in one day, the inpatient day should be counted only in the patient care area in which the patient was located at the census-taking hour. The day of admission will be counted as a full day; however, the day of discharge is not counted. A full day must be counted when a patient is admitted as an inpatient with expectation of remaining overnight and occupying a bed, but is discharged on the same day.

Only one patient day should be counted for a maternity patient in the hospital at the midnight census, whether in the routine care area or in a labor or delivery room.

2. Day of Admission

The day of admission is the day when a person is admitted to a hospital for bed occupancy for purposes of receiving inpatient services and counts as one inpatient day. If admission and discharge occur on the same day, the day counts as one inpatient day except as noted above. If admission and death occur on the same day, the day counts as one inpatient day.

3. Day of Discharge

The day of discharge for a recipient is not counted as a day of patient care, except as noted above. However, charges for ancillary services on the day of discharge are includable in charges for covered services.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986. Amended May 13, 1993. This amendment effective August 12, 1994.

Rule No. 560-X-23-.15 Cost Reporting of Medicaid Cost of Services

(1) General - Annual cost report filing, by completing Medicaid prescribed standard cost report forms, is mandatory for all hospitals. Hospitals with less than 1,000 Medicaid paid/payable days in the reporting year may elect to file an abbreviated report containing certain informational data. NOTE: For these providers, a complete standard cost report must be filed at least once every five years. Hospitals electing to file the abbreviated report will be paid a trended base year rate subject to the limitations applied to all hospitals. All hospitals shall be required to file a complete cost report for the first year following the introduction of the Alabama Medicaid Uniform Cost Report.

(2) Cost Report Year-Ends - Each provider is required to file a uniform cost report for each fiscal year. The provider may elect the last day of any month as the fiscal year end. The cost report is due ninety (90) days after the fiscal year end elected by the provider. To change the fiscal year end, a written request must be received by the Alabama Medicaid Agency no later than sixty (60) days prior to the close of the provider's current cost reporting period. Providers must have written approval from the Alabama Medicaid Agency before changing the reporting period.

(3) Cost Report Filing - Two copies of the complete uniform cost report must be received by Medicaid three months after the Medicaid cost report year-end. Each copy shall by signed by an official or owner of the hospital. If the cost report is prepared by anyone other than an official or a full-time employee of the hospital, such person shall duly execute and submit the report as the Cost Report Preparer. The signatures of both the hospital official and Cost Report Preparer, if any, must be preceded by the following certification:

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

I HEREBY CERTIFY that I have read the above state ment and that I have examined the accompanying Cost Report and supporting schedules prepared on behalf of
(hospital name(s) and Number(s)) for the cost report period beginning
and ending and that to the best of my knowledge and belief, it is a true, correct, and complete report prepared from the books and records of the hospital(s) in accordance with applicable Alabama Medicaid Reimbursement Princi ples, except as noted.

Signed
Officer or Administrator of Hospital(s)

Cost Report Preparer

By:

Title

Date

Date

Any cost report received by Medicaid without the required original signatures and/or certification(s) will be deemed incomplete and returned to the hospital.

Any computer forms submitted with the cost report must be approved by Medicaid prior to year-end filing. Medicaid shall have the authority to prescribe the appropriate conditions upon which computer generated forms can be prepared and submitted.

(4) Extensions - Cost reports shall be prepared with due diligence and care to prevent the necessity for later submittals of corrected or supplemental information by hospitals. Extensions may be granted only upon approval by Medicaid. The extension request must be in writing, containing the reasons for the request, and must be made prior to the cost report due date. Only one thirty-one day extension per cost reporting year will be granted by the Agency.

(5) Penalties

(a) Late Filing - If a complete uniform cost report is not filed by the due date, the hospital shall be charged a penalty of one hundred dollars per day for each calendar day after the due date. This penalty will not be a reimbursable Medicaid cost. The Commissioner of Medicaid may waive such penalty for good cause shown. Such showing must be made in writing to the Commissioner with supporting documentation. A cost report that is over ninety (90) days late may result in termination of the hospital from the Medicaid program. Further, the entire amount paid to the hospital during the fiscal period with respect to which the report has not been filed will be deemed an overpayment. The hospital will have thirty (30) days to refund the overpayment or submit the cost report after which Medicaid may institute a suit or other action to collect this overpayment amount. No further payment will be made to the hospital until the cost report has been received by Medicaid.

(b) Reporting Negligence

1. Whenever a provider includes a previously disallowed disallowed cost on a subsequent year's cost report, if the cost included is attributable to the same type good or service under substantially the same circumstances as resulted in the previous disallowance, a negligence penalty of up to $10,000 may be assessed at the discretion of the Alabama Medicaid Agency.

2. The penalty imposed under Rule No. 560-X-23-.15(5)1 of this Code shall be in addition, and shall in no way affect Medicaid's right to also recover the entire amount of any overpayment caused by the provider's or its representative's negligence.

3. A previously disallowed cost, for the purposes of a negligence penalty assessment, is a cost previously disallowed as the result of a desk review or a field audit of the provider's cost report by Medicaid and such cost has not been reinstated by a voluntary action of Medicaid. The inclusion of such cost on a subsequent cost report by the provider, or its representative, unless the provider is pursuing an administrative or judicial review of such disallowance, will be considered as negligent and subject to the penalty imposed by this Rule.

(6) Termination from the Medicaid Program - Hospitals that terminate participation in the Medicaid program must provide a final cost report within one hundred twenty (120) days of the date of termination of participation. The report may be an abbreviated cost report if the hospital qualifies under Rule No. 560-X-23-.15(1) and elects to file in this manner. In situations involving Medicare and Medicaid termination, Medicaid shall use the same termination date as determined for Medicare. In other situations involving only Medicaid, the effective date of termination will be determined by Medicaid. Medicaid shall demand prompt repayment of all payments made to the hospital during the cost report year of termination in the event the hospital fails to file a final cost report. If a complete uniform cost report is not filed by the due date, the hospital shall be charged a penalty of one hundred dollars per day for each calendar day after the due date by which the receipt of the report by Medicaid is delayed. Further, the entire amount paid to the hospital during the fiscal period with respect to which the report had not been filed will be deemed an overpayment. The hospital will have thirty (30) days to refund the overpayment after which Medicaid may institute a suit or other action to collect this overpayment amount. No further payment will be made to the hospital until the cost report has been received by Medicaid.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986. Amended September 9, 1987; and December 10, 1987 and July 13, 1989. Effective date of this amendment July 19, 1990. This amendment effective May 13, 1993.

Rule No. 560-X-23-.16 Calculation of Medicaid Prospective Payment Rates for Inpatient Claims

Payments for inpatient services shall be based on a prospective per diem rate determined by the Alabama Medicaid Agency.

(1) Rate Setting Period - The as-filed immediately preceding year's cost report will be used to compute a hospital's prospective inpatient per diem rate each year, except for those hospitals on an operating budget or filing an abbreviated cost report, thus the base period is moving. The cost report shall be desk reviewed and any non-reimbursable items will be removed from reported cost prior to calculating a rate.

(2) Rate Review Period - The per diem rates as calculated by Alabama Medicaid Agency shall be provided to the hospitals prior to the effective date for their information and review.

(3) Per Diem Rate Computation - The total Medicaid cost per diems from the cost report shall be adjusted as follows:

(a) The medical education cost per diem and the capital-related cost per diem are subtracted from the inpatient hospital cost per diem. The remaining cost per diem is separated into Administrative and General (A & G) and non-Administrative and General per diem components. The components will then be multiplied by the applicable hospital industry trend factor (as adjusted by any relevant trend factor variance). The resulting trended A & G cost per diem will be arrayed within hospital grouping in ascending order. The number of hospitals in each urban grouping will be multiplied by 80% to determine the position of the hospital that represents the 80th percentile. That hospital's cost in each urban grouping will become the ceiling for that grouping. The ceiling or actual cost per day (whichever is less) will be the adjusted Administrative and General

per diem cost. Add the adjusted (if applicable) A & G per diem component cost to the non-administrative per diem component cost. Psychiatric hospitals shall be subject to a 60th percentile ceiling as described above. Rural and unique hospitals shall not be subject to an overall ceiling limitation.

(b) Capital-Related and Medical Education Costs Per Diem:

1. Adjust capital-related cost for all hospitals per diem by any applicable low occupancy cost per day. (Rural hospitals shall not be subject to a low occupancy adjustment).

2. Medical Education cost per diem will be multiplied by the hospital industry medical education costs trend factor.

(c) The total Medicaid per diem cost per day, subject to the overall 80th percentile ceiling, shall consist of:

1. Operating costs as adjusted in (a) above.

2. Capital-related costs as determined in (b)(1) above.

3. Return on Equity per day, if applicable for proprietary hospitals. Such allowance for Return on Equity shall be eliminated over a three year period. Beginning with the 7/1/88 rate period, payment will be 75% of the amount as normally calculated (under Rule No. 560-X-23-.12); 7/1/89, 50%; 7/1/90, 25%, and zero thereafter.

(d) Such total Medicaid costs per day shall be separated into the applicable hospital grouping. Within the grouping, the total cost per day will be arrayed in ascending order. The number of hospitals in each grouping will be multiplied by the applicable percentile to determine the position of the hospital that represents the appropriate percentile. That hospital's cost in each grouping will be the ceiling for that grouping. Hospitals determined to be unique or rural by the Agency are not subject to these ceilings. Urban I hospitals shall be subject to a 90th percentile ceiling.

(e) The lesser of the above determined ceiling or actual cost per day shall be added to any applicable education cost as adjusted in (2)(b). The sum shall be a hospital's Medicaid per diem rate for the new period.

(4) Enhanced Payments - Publicly owned acute care hospitals may be paid an enhanced payment not to exceed Medicare Upper Limits in the aggregate. The payment will be determined by the following methodology:

(a) Publicly owned acute care hospitals in the Urban groupings may be paid an amount above any applicable ceilings up to their computed cost, less any low occupancy adjustment, multiplied by Medicaid paid days.

(b) All publicly owned acute care hospitals may be paid an amount determined by: The computed per diem cost multiplied by a percentage determined by the Alabama Medicaid Agency for Medicaid days served by the hospital (including Health Maintenance Organization (HMO) and Maternity Waiver days).

(5) Acute care hospitals whose inpatients are predominantly under 18 years of age may be paid an enhanced payment not to exceed Medicare upper limits in the aggregate. The enhanced payment will be the Medicaid computed per diem rate multiplied by thirty percent for all paid Medicaid days.

(6) Adjustments to Rates - The prospectively determined individual hospital's reimbursement rate may be adjusted as deemed necessary by the Agency. Circumstances which may warrant an adjustment include, but are not limited, to:

(a) A previously submitted and/or settled cost report that is corrected. If an increase or decrease in rate results, any retroactive adjustments shall be applied as of the effective date of the original rate. Any such payment or recoupment shall be made by a rate change and/or a lump sum adjustment if the adjustment applies to the current rate period, or by a lump sum adjustment, if the adjustment applies to a prior rate period.

(b) The information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. This may be considered grounds to suspend the hospital from participation in the Alabama Medicaid Program.

(c) The hospital experiences extraordinary circumstances which may include, but are not limited to, an Act of God, war, or civil disturbance. Adjustments to reimbursement rates may be made in these and related circumstances.

(d) Under no circumstances shall adjustments resulting from paragraphs (a) through (c) above exceed the group ceiling established. However, if adjustments as specified in (a) through (c) so warrant, Medicaid may recompute the group ceilings.

(7) Approved Capital Expenditure Projects

(a) For those hospitals with approved capital expenditure projects that desire an immediate adjustment of the prospective rate for a current reporting year, the following procedures and/or any other procedures deemed necessary by the Agency will be performed to reimburse the approved CON projects of those hospitals which qualify under the above-listed circumstances:

1. The hospital will submit a budgeted cost report containing estimated total Medicaid cost.

2. The Agency will compute a budgeted per diem rate subject to the current ceiling. This rate must exceed the hospital's current rate by at least 10% (if the current rate is not limited by the overall ceiling) in order to be considered for a rate increase.

3. The total budgeted rate is subject to retroactive adjustment after comparison to the rate calculated from the applicable cost report containing actual allowable costs.

(8) Trend Factor Variance - During the rate setting period, the projected trend factor used in calculating the per diem rate for the prior year shall be compared to the actual trend factor. If the difference between the projected and actual trend factor was greater than one-half percent, an adjustment shall be made. If such adjustment is applicable, it shall be made by adding to or subtracting from the current trend factor.

(9) Low Occupancy Adjustment - A low occupancy adjustment shall be computed for hospitals which fail to maintain the minimum level of occupancy of the total licensed beds. A 70% occupancy factor will apply to hospitals with 100 or fewer beds. An 80% occupancy factor will apply to hospitals with 101 or more beds. Such adjustment will be composed of the fixed cost associated with the excess unoccupied beds and shall be a reduction to Medicaid inpatient cost. It shall be computed in the manner outlined as follows:

LOW OCCUPANCY ADJUSTMENT FOR HOSPITALS

$$LOA = \left(1 - \frac{TBD}{Y \cdot ABD}\right) ACC$$

TBD = Total Bed Days Actually Used During the Cost Report Period, Exclusive of Nursery Bassinets and/or Separately Certified Non-Covered Units (i.e. psych.)

ACC = Allowable Capital Cost

ABD = Available Bed Days Which is Determined by Multiplying the

Y = Occupancy Factor (Y = 70% 100 beds or

Total Licensed Beds Times the Number of Days in the Cost Report Period, Exclusive of Nurserty Bassinets and/or Separately Certified Non-Covered Units (i.e. psych.)	less (Y = 80% 101 beds or more	

(10) New Hospital Facilities - A new facility shall submit a budget of cost for Medicaid inpatient services for its initial cost reporting period. The Alabama Medicaid Agency will determine a per diem rate from this budget. The rate for payment of services provided shall be limited to the lower of the budgeted per diem rate or the ceiling rate of the group in which this facility will fall.

After the actual cost report is filed for the budgeted period, the Alabama Medicaid Agency will calculate a per diem rate in order to determine if any under or overpayment has been made to the hospital. The lower of the actual per diem rate or the group ceiling rate will be used to determine this cost settlement. Any amounts due to or from the hospital will be paid or recouped by a rate change and/or lump sum adjustment.

(11) Changes of Ownership - If a facility changes ownership, one of the following rules shall apply:

(a) If the new owner's initial cost report will be for a period of less than six months, an interim per diem rate shall be paid. Such rate shall be the prior owner's per diem rate plus a trend factor.

(b) If the new owner's initial cost report will be for a period of six months or more, the new owner's cost report will be used for rate setting purposes.

(c) New owners must file a complete Medicaid cost report for their first reporting period under Alabama's Medicaid program. Subsequent reports may be filed under the abbreviated cost reporting Rule No. 560-X-23-.15(1) if the hospital qualifies and so elects.

(d) In a transfer which constitutes a change of ownership, the old and new providers shall reach an agreement between themselves concerning trade accounts payable, accounts receivable, and bank deposits. Medicaid will pay the new provider for unpaid claims for services rendered both prior to and after the change of ownership. The new provider shall be liable to Medicaid for unpaid amounts due
Medicaid from the old provider.

(12) Hospitals Which Serve a Disproportionate Number of Low Income Patients - Certain payment adjustment shall be provided for in-state hospitals which are determined to be adversely affected because they serve a disproportionate number of low income patients.

(a) In order to be eligible for this payment adjustment, an in-state hospital shall meet the
following criteria:

1. The hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate of all in-state hospital providers participating in the Alabama Medicaid Program; or

2. The hospital's low-income inpatient utilization rate exceeds 25 percent; or

3. Be an acute care teaching hospital operated by a university of the State of Alabama; or

4. Be an acute care publicly owned hospital; or

5. Be an acute care hospital that is a member of a prepaid health plan; or

6. Acute care hospitals in a county, with a population greater than 200,000 (according to the latest U. S. census), without a publicly owned hospital, whose Medicaid utilization exceeds the state wide Medicaid utilization average; or

7. Acute care hospitals in a county, with a population not less than 75,000 and not greater than 100,000 (according to the latest U. S. census), without a publicly owned hospital, whose Medicaid utilization exceeds one-half of the state wide Medicaid utilization average; and

8. Effective for services rendered on or after July 1, 1988, the hospital must have at least two (2) obstetricians, with staff privileges at the hospital who have agreed to provide non-emergency obstetric services to individuals entitled to such services under the Alabama Medicaid Program. (In the case of a hospital located in an area designated by Medicaid as rural, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.) Hospitals which did not offer routine obstetrical services to the general public as of December 21, 1987, or whose inpatients are predominantly individuals under 18 years of age are exempt from the requirement. Should a hospital begin offering non-emergency OB services on or after December 21, 1987, the above requirement to have two obstetricians applies; and

9. Have a Medicaid inpatient utilization rate of not less than one percent.

(b) If the criteria listed in (12)(a) are met, the payment adjustment shall be determined as follows:

1. A factor of one quarter of one percent for every percentage point the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate (with a minimum of one quarter of one percent) or for every percentage point the hospital's Low Income Utilization Rate exceeds twenty-five percent shall be computed.

2. The applicable factor from (12)(b) 1. shall be applied to the hospitals' allowable calculated per diem rate (excluding any education cost flow-through). The hospital shall be reimbursed its factored per diem rate plus any applicable education cost flow-through.

3. In the instance of a hospital meeting two or more of the applicable criteria contained within (12)(a), two or more factored per diems shall be calculated using the Medicaid Inpatient Utilization Factor and the Low Income Utilization Factor as in (12)(b) 1. The hospital shall be reimbursed at the lower of the two or more factored per diems plus any applicable education cost flow-through.

(c) As an alternative payment method, based upon availability of funds to be appropriated, hospitals meeting the applicable criteria in (12)(a) above and which do not have their disproportionate share payment included in a capitation payment rate shall be compensated as follows:

1. Disproportionate share hospitals shall be grouped into eight groups as follows:

Group 1: Acute care hospitals whose inpatients are predominantly under 18 years of age.

Group 2: Acute care publicly owned hospitals.

Group 3: Acute care hospitals located in a rural area and acute care hospitals licensed for one-hundred (100) beds or less

and located in a metropolitan statistical area (MSA).

Group 4: Psychiatric hospitals owned and operated by the State of Alabama.

Group 5: Psychiatric hospitals other than those owned and operated by the State of Alabama which provide services to individuals under 21 years of age.

Group 6: Acute care hospitals in a county, with a population greater than 200,000 (according to the latest U. S. census), without a publicly owned hospital, whose Medicaid utilization exceeds the state wide Medicaid utilization average.

Group 7: Acute care hospitals in a county, with a population not less than 75,000 and not greater than 100,000 (according to the latest U. S. census), without a publicly owned hospital, whose Medicaid utilization exceeds one-half of the state wide Medicaid utilization average.

Group 8: Be an acute care hospital that is a member of a prepaid health plan.

2. Annually, the Alabama Medicaid Agency shall determine a sum of funds to be appropriated to each group of hospitals, in lieu of the payment methodology contained in Section (11)(b)1. Disproportionate share payments to any hospital shall not exceed uncompensated cost of care as defined in OBRA 93. Subject to this limitation, calculation of the funds shall be as follows:

Group 1
Uncompensated Cost / Total Uncompensated Cost for Hospitals in Group One X Appropriated Funds = Disproportionate Share Payment

Group 2
Uncompensated Cost / Total Uncompensated Cost for Hospitals in Group Two X Appropriated Funds = Disproportionate Share Payment

Group 3
Medicaid Inpatient Days / Total Medicaid Inpatient Days for Hospitals in Group Three X Appropriated Funds = Disproportionate Share Payment

Group 4
Medicaid Inpatient Days / Total Medicaid Inpatient Days for Hospitals in Group Four X Appropriated Funds = Disproportionate Share Payment

Group 5

Medicaid Inpatient Days Total Medicaid Inpatient Days for Hospitals in Group Five	X	Appropriated Funds	=	Disproportionate Share Payment
Group 6 Hospital Total hospitals in Group Six	X	Appropriated Funds	=	Disproportionate Share Payment
Group 7 Hospital Total hospitals in Group Seven	X	Appropriated Funds	=	Disproportionate Share Payment
Group 8 Uncompensated Care Total Uncompensated care in Group Eight	X	Appropriated Funds	=	Disproportionate Share Payment

(13) Medicare Catastrophic Coverage Act [Section 302(b)(2) Day and Cost Outliers].

(a) The Alabama Medicaid Agency has lifted the durational limits for medically necessary services provided to children under the age of 6 years in hospitals deemed by the Agency as disproportionate and for children under one year old in all hospitals. Because we pay for all medically necessary days of care for these children, we meet the day outlier requirement.

(b) Cost Outliers

1. A cost outlier for an extremely costly length of stay for children under six years of age receiving medically necessary services in a hospital deemed by the Alabama Medicaid Agency as disproportionate or an infant under age one in any hospital, is defined as a claim for payment for a discharged child for allowable services rendered from the date of admission to the date of discharge which meets the following criteria:

The Medicaid allowed charges per day for the length of stay must exceed 4 times the hospital's mean total charge per day for Medicaid eligible infants under one year of age in all hospitals or under 6 years of age in disproportionate share hospitals (as established by Medicaid from Agency paid claim data).

2. Payment of Cost Outliers

The sum of allowed charges in excess of 4 times the mean total charge per day shall be multiplied by the hospital's current rate period percent of total Medicaid cost to total Medicaid charges (per Worksheet C of the Medicaid Cost Report) to establish the amount to be paid as a cost outlier. The outlier payment shall be limited to a total of $10,000 per discharge and $50,000 per child during the per diem rate cycle July 1 through June 30.

A hospital having a claim which meets the criteria for a cost outlier must present the claim(s) documentation to the Alabama Medicaid Agency for review after the claim(s) have been adjudicated. Subsequent to review and approval, payment shall be made as a lump sum.

(14) Rate of Return on Equity Capital

The rate of return percentage shall be equal to the average of the rates of interest on special issues of public debt obligations issued to the

Federal Hospital Insurance Trust Fund for each of the months during the hospital's reporting period or portion thereof covered under the program.

(15) Prepaid Health Plan (PHP)

(a) As of October 1, 1995, an alternative to paying a per diem rate to each hospital for inpatient services, hospitals in a contiguous geographic area may form an organization or entity, i.e., a Prepaid Health Plan (PHP). The PHP would contract with the Alabama Medicaid Agency to provide inpatient hospital services to Medicaid eligibles residing in the PHP's geographic area under a capitated payment arrangement. The disproportionate share payments for the hospitals in the PHP would be added to the capitated payments.

(b) Capitation Rate Methodology:

(1) The capitated rate would be as follows:

Historical Cost	(b)(2)a	=	Payment
Eligible Months	(b)(2)b		Per Member Per Month

(2) The capitation rate methodology will be as follows:

a. The Medicaid historical inpatient hospital costs will be obtained from Medicaid paid claims listing for all of the participating hospitals in each geographic PHP. The base period will consist of one year (July 1 through June 30) which will be at least six months prior to the effective date. Based period cost will be trended to current year.

b. Eligible months are defined as the total number of months Medicaid only eligibles were certified for eligibility during the base period, excluding Sobra adults in maternity waiver counties.

(c) Disproportionate share hospitals payment: The sum of the disproportionate share payments that would be payable to the individual hospitals that are eligible to be members of the PHP, not to exceed that amount allowed under OBRA '93.

(d) Payments:

(1) The PHP would receive a monthly capitated payment for each eligible, plus the PHP disproportionate share payment.

(2) Medicaid shall not pay a PHP more for inpatient hospital services under a capitation rate than the cost of providing those services under the regular inpatient hospital payment methodology.

(3) Capitation payment to the plan for all eligible enrollees shall be made monthly.

(4) Payments described in Section III,(h) pages 6B and 6C of Attachment 4.19-A of the Alabama Medicaid State Plan will be paid directly to the appropriate hospitals as defined in Section III,(h).

Authority: State Plan; Attachment 4.19-A, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) Rule effective June 9, 1986. Rule amended September 8, 1986, October 11, 1986; December 10, 1987; May 25, 1988, November 10, 1988; and April 14, 1989. Emergency rule effective September 29, 1989. Amended December 13, 1989. Emergency rule effective January 2, 1990. Amended March 14, 1990, July 19, 1990, and August 14, 1990. Emergency rule effective July 1, 1991. Emergency rule effective October 1, 1991. Amended December 12, 1991 and September 11, 1992. Emergency rule effective October 1, 1993. Emergency rule repealed and replaced effective October 1993. Permanent rule effective February 10, 1994. Amended June 14, 1994 and July 13, 1994. Amended October 1, 1994.

Emergency rule effective January 1, 1995. Amended March 15, 1995 and September 12, 1995. Emergency rule effective October 1, 1995. Effective date of this amendment is November 10, 1995.

Rule No. 560-X-23-.17 Calculation of Medicaid Prospective Payment Inpatient Rate for Out-of-State Hospitals

(1) Payment for inpatient services provided by all out-of-state hospitals shall be the lesser of submitted covered charges or the Alabama flat rate which shall be composed of the average of the per diem rates paid to in-state hospitals for inpatient services. This rate shall be subject to change..

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986.

Rule No. 560-X-23-.18 Audit

(1) To insure that payment of inpatient hospital costs is being made on a reasonable basis, comprehensive hospital desk review and audit programs have been developed. Using these programs, Medicaid shall perform the following:

(a) Desk review the cost reports as filed and include the appropriately determined allowable cost in the prospective per diem rate calculations;

(b) Determine the necessity, scope, and format for on-site audits;

(c) Perform on-site audits when indicated in accordance with Title XIX principles of reimbursement, and;

(d) Recalculate, when appropriate, the prospectively determined per diem rates giving effect to audit adjustments.

(2) The following records and/or documentation, as a minimum, must be available at the audit site no later than seventy two (72) hours after official notification that an audit will be conducted:

(a) Detailed general ledger
(b) Payroll register
(c) Detailed payables register
(d) Property and depreciation ledger
(e) Floor plans of the hospital's facilities
(f) Daily and monthly census reports
(g) Medicaid log
(h) Copies of all CON's (approved or submitted pend ing approval)
(i) Form 941's
(j) Minutes of the Board of Directors meetings
(k) Copy of audited financial statements
(l) Copy of Home Office Cost Report
(m) Organization Chart (Facility)
(n) Flow chart or narrative description of key ac counting system
(o) Corporate organization chart which includes subsidiaries and/or affiliates

(3) In the event a Medicaid auditor or investigator is required to travel out-of-state during an audit, the organization being audited will bear all expenses and costs related to the audit, including, but not limited to,

travel and reasonable living expenses. These costs will not be allowable on any subsequent cost report.

Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986. Effective date of this amendment December 10, 1987. Effective date of this amendment May 13, 1993.

Rule No. 560-X-23-.19 Appeals

(1) Hospital administrators who disagree with the findings of the Medicaid desk audits or field audits may request in writing an informal conference. Such written requests must be received by the Chief Auditor, Provider Audit within thirty (30) days of the date of notification of the preliminary audit findings or new reimbursement rate is mailed and must specify the issue(s) on which the conference is requested.

(2) If the result of the informal conference is adverse to the hospital, an administrator may request a Fair Hearing in writing. Such request must be received by the Agency within fifteen (15) days of the date of notification of the results of the informal conference is mailed and must specify the issue(s) on which the hearing is requested. Any appeal is limited to issues which were raised in the informal conference request.

(3) The following items will not be subject to appeals:

(a) The use of Medicaid standards and principles of reimbursement.
(b) The method of determining the trend factor.
(c) The use of all-inclusive prospective reimbursement rates.
(d) The use of hospital group ceilings.

(4) A hospital may, on the basis of appeal, be granted an exception for one rate period only. Any further exceptions must be appealed individually. As a condition of appeal, the Alabama Medicaid Agency may require the hospital to submit to a comprehensive operational review. Such review will be made at the discretion of the Alabama Medicaid Agency and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986. Effective date of this amendment May 13, 1993.

Rule No. 560-X-23-.20 Other Matters

(1) Hospital Based Physicians

All hospital based physicians, including emergency room physicians, shall either bill the Medicaid Program on a HCFA-1500, Health Insurance Claim Form or assign their billing rights to the hospital, which shall bill the Medicaid Program on a HCFA-1500 form.

(2) Ambulance Services

(a) Effective for cost reporting periods beginning January 1, 1982, and thereafter, ambulance service costs are nonallowable for Medicaid hospital reimbursement purposes.

(b) In order to be reimbursed for ambulance services provided to Medicaid recipients, a hospital with an ambulance service shall enroll as a

provider in the Alabama Medicaid Transportation Program. (See Chapter 18, this Code.)

(3) Split Billing as of June 30 each year.

Due to the changes in the Medicaid inpatient reimbursement methodology on June 30, 1986, it shall be necessary for a hospital to "split bill" for inpatient services each year as of June 30. This "split billing" period shall be necessary for the hospital and the Alabama Medicaid Agency to determine a payment for services provided through June 30 each year.

(4) Split Billing as of December 31 each year.

Split billing shall also be required at December 31 each year so that Medicaid can make a proper and accurate cut-off for recipient eligibility determination purposes.

(5) Interim Rate Period

The first cost reports required under the new methodology as promulgated in this Chapter will be due June 30, 1986. There will be an interim rate period from October 1, 1986 to June 30, 1987. The per diem rates effective during this period will be computed under the previous methodology using the latest settled Medicare/Medicaid cost report available as of May 31, 1986, with the following exceptions:

(a) Each hospital's trended operating cost per day, return on equity cost per day (if applicable), and capital cost per day will be added together.

(b) The resulting total hospital costs per day will be arrayed within the urban/rural groupings in ascending order.

(c) The number of hospitals within each grouping will be multiplied by 60% to determine the position of the hospital that represents the 60th percentile. That hospital's cost in each grouping will become the ceiling for that grouping.

(d) The lesser of the sum of costs as per step (1) or the ceiling cost per day as per step (3) shall be added to any applicable adjusted education cost. The sum shall be a hospital's Medicaid per diem rate for the new period.

(6) Amended Medicare/Medicaid Cost Reports

Inpatient and outpatient retroactive settlements on amended Medicare/Medicaid cost reports with fiscal years ending prior to October 1, 1984, will no longer be processed for payment by or to the Alabama Medicaid Agency.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 447.251-271, et seq. Rule effective June 9, 1986. Amended September 8, 1986. Effective date of this amendment June 10, 1987.

Rule No. 560-X-23-.21 Determination of Final Prospective Rate and Settlement of Related Medicaid Cost Reports

(1) Time periods related to determination of final prospective rates and settlement of related Medicaid cost reports.

(a) Commencement of an Audit:

An audit of a cost report must be commenced by Medicaid within three calendar years after the due date or filing date (whichever is later) of the cost report. In such cases where an audit has not been commenced within the three year period noted above, the cost report subject to examination shall be considered final and shall not be subject to further examination by Medicaid.

The only exception to this shall be where potential fraud or intentional misrepresentation by the hospital is indicated.

(b) Settlement of cost reports not audited:

A cost report not audited shall, subject to the absence of potential fraud or intentional misrepresentation by the hospital, be considered final as of three years of the filing date or the due date, whichever is later. Any and all rates and other payment data extracted from such cost reports shall also be considered final and shall not be subject to revision by Medicaid or the hospital.

(c) Settlement of audited cost reports:

A cost report upon which an audit has been commenced within three years after the due date or the filing date of the cost report, whichever is later, shall be considered final as of four years of the later of the filing date or due date. An exception to this may arise where the hospital has not furnished Medicaid with facts necessary for the completion of the audit. Requests for such facts must be communicated in writing by Medicaid to the hospital at least three months before the date which falls four years after the later of the due date or filing date of the cost report. When the written request for information is issued by the time prescribed above, the report will be considered closed upon the issuance of the final report of the results of the audit. However, the hospital's right of appeal as outlined in Chapter Three of these regulations shall continue to apply. When the written request is not transmitted to the hospital within the time prescribed above, the cost report shall be considered final as of four years after the later of the due date or filing date. These limitations shall not apply where potential fraud or intentional misrepresentation by the hospital is indicated.

(2) Audit Adjustment Procedures

(a) Audit adjustments after rate year has commenced:

1. Audit adjustments will be paid or collected by a combination of (1) changing the per diem rate of the hospital and (2) a lump sum settlement for the amount under/over paid for the period prior to the effective date of the per diem rate change.

2. All adjustments will be subject to the limitations set out in this Chapter and subject to the appropriate ceilings.

3. Collection procedures will be initiated only after the expiration of all rights of administrative appeal.

4. A final report of the results of an audit will be forwarded to each hospital upon completion of each audit. An adjusted per diem rate will be stated in the report of audit and will be computed based on audit adjustments. This new per diem rate will be effective for billing purposes on the 1st day of a month (allowing for a thirty (30) day notification period and a reasonable amount of time for processing the report of audit).

(b) Audit adjustments prior to commencement of rate year:

Audit adjustments proposed prior to the commencement of the hospital's rate year shall be used in computing the hospital's rate for that rate year.

Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq. Rule effective June 9, 1986. Effective date of this amendment September 9, 1987.